Electronically delivered
December 29, 2021

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: December 17, 2021

Dear Administrator:

On December 17, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 13, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Madison Healthcare Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 17, 2022 if your facility does not achieve

substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	C 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE MADISON, MN 56256**

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F 000	INITIAL COMMENTS From 12/15/21 through 12/17/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5382043C (MN78324) and H5382045C (MN79312), with a deficiency issued at F689. The following complaints were found to be SUBSTANTIATED: H5382041C (MN79191) and H5382042C (MN77817), however no deficiencies were issued. The following complaint was found to be UNSUBSTANTIATED: H5382044C (MN79315). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		1/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/03/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly implement fall prevention interventions to prevent reoccurring falls for 2 of 3 residents (R5, R3) reviewed for accidents. This deficient practice resulted in actual harm for R5, who sustained thoracic spine comprehension fractures. Findings include: R5's Face Sheet dated 7/11/19, indicated R5 was admitted to the facility on 7/11/19, with initial diagnoses of weakness and repeated falls. R5's Diagnosis Report updated 12/13/21, added the diagnosis of wedge compression fracture of thoracic vertebra. R5's Quarterly Minimum Data Set (MDS) assessment dated 10/13/21, indicated R5 scored 9 of 15 on the brief interview for mental status (BIMS) which signifies moderate impaired cognition, and functional status identifying R5 needing extensive assistance with bed mobility, transferring, locomotion, dressing, toileting, personal hygiene, and walking did not occur. R5's Care Plan falls focus area last revised 11/18/20, identified R5 as moderate risk for falls. Fall prevention interventions included: 7/29/19, anticipate and meet R5's needs; 7/29/19, be sure call light is within reach and encourage to use;	F 689	F689 Free of Accident Hazards/Supervision/Devices • How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R5 had new interventions added to his care plan on 12/16/21 as follows: 1. Bed will be in the lowest position, 2. Fall mat next to the bed on the right side, 3. 30 minute safety checks which are documented in the TAR by the nurse, 4. Video Monitoring in room requested by family to monitor movement from resident. R3 was discharged from this facility on 11/29/21. Education will be provided to staff in the form of reviewing the falls policy that was updated in October of 2021 and all regularly scheduled staff will sign off that they have read and understand the falls policy. (Please note: Updated Falls policy and education were started before survey at Staff meeting held 10/26/21. 7 out of 50 staff were present at staff meeting.) Falls will be reviewed at stand up after every fall. The Falls analysis report if opened and completed by nurse reporting fall will be reviewed. (The falls analysis report in PCC replaced the paper form of the Root Cause Analysis) If there are interventions in the Falls analysis report they will be added into the plan of care for that	

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F 689	Continued From page 2 7/29/19, ensure R5 is wearing appropriate footwear; 7/29/19, follow facility fall protocol; 7/29/19, physical therapy to evaluate and treat as ordered/as needed; and 11/18/20, requires assist of one for all transfers and has a history of self-transferring. A Fall Risk Assessment dated 12/17/21, indicated R5 scored 17, meaning at high risk for falls. Document review indicated R5 had the following falls: On 09/19/21, at 6:10 p.m. staff were notified by another resident that R5 was yelling and concerned he may have fallen. Staff responded and found R5 sitting on the floor next to his bed and wheelchair. R5 stated he was trying to go to the bathroom. R5 sustained a skin tear on his left elbow. The incident report noted and fall assessement was completed and fall prevention interventions of ensure call light, cell phone, and wheelchair are within reach. However, R5's care plan was reviewed and lacked evidence the fall interventions were added and implemented post fall. The incident report further documented that R5 has had seven falls since his admission on 7/11/19. On 12/04/21, at 9:00 p.m. resident activated his call light to summon help because he had fallen while trying to go to the bathroom. Staff found R5 sitting on the floor between his bed and wheelchair. R5 did not sustain an injury. The incident report documented fall assessment was completed and fall prevention interventions of ensure call light is within reach, wear appropriate footwear, and to add offer toilet every two hours at night if awake. R5's care plan was reviewed and lacked evidence the new fall intervention was	F 689	resident. If there are not interventions in place in the Falls Analysis report the IDT will analyze the fall and place the interventions in the plan of care. • How the facility will identify other residents having the potential to be affected by the same deficient practice: Other residents who have fallen will be identified by the facility as having the potential to be affected by the same deficient practice. • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Education will be provided to staff in the form of reviewing the falls policy that was updated in October of 2021 and all regularly scheduled staff will sign off that they have read and understand the falls policy. (Please note: Updated Falls policy and education were started before survey at Staff meeting held 10/26/21. 7 out of 50 staff were present at staff meeting.) Falls will be reviewed at stand up after every fall. The Falls analysis report if opened and completed by nurse reporting fall will be reviewed. If there are interventions in the Falls analysis report they will be added into the plan of care for that resident. If there are not interventions in place in the Falls Analysis report the IDT will analyze the fall and place the interventions in the plan of care. Stand up documentation of IDT minutes are in an Excel spread sheet labeled “Madison Healthcare Services Care Center IDT Meeting Minutes” with a section labeled “Risk Management” to	

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F 689	Continued From page 3 added and implemented post fall. The incident report further documented that R5 has had eight falls since his admission on 7/11/19. On 12/05/21, at 5:00 p.m. staff performing bed checks found R5 lying on the floor in the corner of the room. R5 stated he did not know what he was doing but maybe going to the bathroom. R5 complained of left rib pain. The incident report documented a fall assessment was completed but lacked evidence fall interventions were developed or implemented to reduce the likelihood of future falls for R5 post fall. On 12/10/21, at 11:45 a.m. staff passing by R5's room heard him yelling for help. R5 was found sitting on the floor next to his bed. R5 stated no one pays attention to him and ignores his cries for help. The incident report documented no injuries. The Post Fall Assessment dated 12/13/21, documented the fall resulted in a fracture and that the care plan was reviewed. Hospital discharge summary dated 12/10/21, diagnosed R5 with T8-T9 thoracic compression fractures. The hospital summary also documented that R5 had fallen out of bed on three occasions. The incident report documented a fall assessment was completed lacked evidence fall intervention were developed or implemented to reduce the likelihood of future falls for R5 post fall. On 12/14/21, at 4:50 p.m. R5 was found sitting on the floor holding onto the mobile table. The incident report documented R5 did not have any injuries. The 24-Hour Post Fall Assessment documented that R5 is at risk for further falls due to restless behavior and inability to make his needs known. The incident report lacked evidence fall intervention were developed or	F 689	review falls, etc. • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will audit the Falls Analysis report in PCC to ensure it is being opened and completed after each fall. This will be brought to QAPI monthly. The DON or designee will audit the care plan for new interventions and if they have been effective or not for all falls. This will be brought to QAPI monthly as well. Reviewing the Falls policy at staff meetings will be a running monthly agenda item. • The date that each deficiency will be corrected: Each deficiency (F689) will be corrected and staff will educated by January 17, 2021.	

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implemented to reduce the likelihood of future falls for R5 post fall.

On 12/16/21, at 10:09 a.m. R5 was observed being wheeled to his room from the dining room. R5 was unable to hold his feet up and staff were observed frequently stopping to let the resident rest. R5 was leaning over to his left side with the arm rest holding him up.

During an interview on 12/16/21, at 10:01 a.m. R5 stated he is not doing very well. He stated he was in constant pain from the fall and could not get comfortable. During the interview R5 was observed to hold his left side and was continually rolling from side to side and attempting to sit up. R5 stated he just could not find a comfortable position. R5 stated he received pain medication, but it barely helped alleviate the pain. R5 further stated he is so weak that he could not walk and was only able to pivot transfer. R5 stated he knows he should not transfer by himself, but it takes too long for staff to respond to his call light.

During a family interview on 12/13/21, at 9:00 a.m. the family stated they had safety concerns with R5 being discharged from the hospital to the nursing home because of the multiple falls R5 had sustained. Two members of the family FM-(A) and FM-(B) met with assistant director of nursing (ADON) and registered nurse (RN)-B. FM-A and FM-B questioned what the facility was going to do for safety and how to prevent another fall. ADON and RN-B stated they will put the bed in the lowest position, placed a fall mat next to the bed, and will start performing 30-minute safety checks. FM-A and FM-B stated R5 sustained a fall at the facility approximately a year ago and now R5 had another back injury. FM-A and FM-B

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also stated that R5 is now on hospice care due to his thoracic compression fractures.

During an interview on 12/16/21, at 10:16 a.m. NA-B stated NAs do not fill out incident reports or have access to view them; only nursing staff complete the forms and have access to them. NA-B stated that R5's safety interventions are in POC and have not changed. NA-B further stated, when a fall prevention intervention is added in the care plan, it is linked to their Kardex (Point of Care) and they receive a notification that a new responsibility or intervention has been added. NA-B stated she was not unsure what R5's fall interventions were previous to his hospital stay.

During an interview on 12/16/21, 12:10 p.m. licensed practical nurse (LPN)-A stated floor nursing staff enter new fall prevention interventions on the Falls Assessment and the CCC enters them into the care plan. LPN-A stated she was unsure if there were any changes in the care plan for R5 and she was not aware of fall interventions for him previous to his return from the hospital.

R3's Face Sheet dated 7/24/17, indicated R3 was admitted to the facility on 7/24/17.

R3's Diagnosis Report dated 7/24/17, indicated R3 diagnosis included Alzheimer's disease, dementia, anxiety, restless and agitation, and history of falling.

R3's Quarterly MDS assessment dated 10/22/21, indicated R3 scored 3 of 15 on the BIMS assessment, signifying R3 as severely impaired cognition; physical behaviors symptoms towards others, such as hitting, kicking, or pushing; uses

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a walker for mobility; and requires extensive assistance with dressing, toileting, and personal hygiene.

R3's Care Plan, falls focus area was last revised 4/10/18. Fall prevention interventions included: R3 requires supervision with ambulation, keep room and pathway free of clutter, may walk around in bare feet, and WanderGuard placed.

A Fall Risk Assessment dated 11/05/21, indicated R3 scored 14, meaning at moderate risk for falls.

Record review revealed R3's discharged to another nursing facility on 11/29/21.

Document review indicated R3 had the following falls:
On 9/21/21, at 7:45 a.m. R3 was found on the floor next to her bed. The walker was in the bathroom and there was water on the floor as well as clothes all over her room. R3 did not sustain an injury. Documentation indicated R3 has had sixteen falls since her admission on 7/24/17. The incident report documented fall prevention interventions of anticipate R3's needs, be sure call light is within reach, provide a safe environment with floors free from spills and clutter, and ensure walker is always within reach. R5's care plan was reviewed and lacked evidence the new fall interventions were added and implemented post fall.

On 11/01/21, at 5:30 a.m. staff heard a thud from R3's room and upon investigation, R3 was found lying on the floor by her bed. During an assessment for injuries, it was found that R3 sustained a 0.25 cm x 7.0 cm laceration to the back of her head. R3 was taken to the nurse's

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F 689	Continued From page 7	F 689		

station and a cold pack was applied to the wound. The incident report lacked evidence of new fall interventions but noted interventions from fall on 9/21/21 were not care planned post fall of anticipate R3's needs, be sure call light is within reach, provide a safe environment with floors free from spills and clutter, and ensure walker is always within reach. R3's care plan was reviewed and lacked evidence the fall interventions were added and implemented post fall for 11/1/21 fall as well.

During an interview on 12/16/21, 10:27 a.m. ADON stated the new interventions that were placed for R5 include keeping the bed in lowest position, fall mat next to the bed, and 30-minute safety checks. ADON indicated that the clinical care coordinator (CCC) is responsible to enter care interventions in the Treatment Administration Record (TAR) and to update the care plan adding, if there are not any fall prevention interventions in the care plan for the five recent falls then no interventions were created. ADON further agreed that no root cause analysis was completed for the falls. ADON stated it was her expectation that the care plan be updated after every fall for R3 and R5 and this was not getting done.

During an interview on 12/16/21, 11:01 a.m. CCC-A stated she is just becoming aware there is a system issue of who enters fall prevention interventions in the care plan. CCC-A stated it was the floor nurse's responsibility to enter interventions. CCC-A stated the inter disciplinary team (IDT) only briefly discusses falls during the morning stand-up meeting and new interventions are not discussed. CCC-A further stated the facility does not have a falls prevention committee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	C 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE MADISON, MN 56256**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

and QAPI is not tracking if current fall prevention interventions are working or should be updated/revised.

During an interview on 12/16/21, at 9:46 a.m. nursing assistant (NA)-A stated fall prevention interventions are in the Point of Care (POC) section of PointClickCare (PCC) electronic medical record. When a fall prevention intervention is added in the care plan, it is linked to their Kardex (Point of Care) and NA's receive a notification that a new intervention has been added. NA-A explained there have been no new fall prevention interventions because NA's would have been notified that one has been added. NA-A further stated that NAs do not fill out fall incident reports or have access to look at them. This prohibit NA's from viewing fall prevention interventions and being able to implement them. NA state she was unware of R3's fall interventions were previous to her demission or what R5's interventions were previous to his hospital stay.

The facility's policy entitled Falls, last revised 10/21, directed the charge nurse, CCC, or the DON/ADON complete the Fall Root Cause Analysis, investigation, provide intervention from the root cause analysis, and CCC or DON/ADON to update the care plan with the intervention. It was found that the facility is not following the Falls policy.

Electronically delivered
December 29, 2021

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: RZ1111

Dear Administrator:

The above facility was surveyed on December 15, 2021 through December 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	C 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: From 12/15/21 through 12/17/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5382043C (MN78324) and H5382045C (MN79312) with a licensing order issued at 0830. The following complaints were found to be SUBSTANTIATED: H5382041C (MN79191) and H5382042C (MN77817), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5382044C (MN79315). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although	2 000		

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2 000	Continued From page 2 no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly implement fall	2 830	Corrected	1/17/22

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2 830	Continued From page 3 prevention interventions to prevent reoccurring falls for 2 of 3 residents (R5, R3) reviewed for accidents. This deficient practice resulted in actual harm for R5, who sustained thoracic spine comprehension fractures. Findings include: R5's Face Sheet dated 7/11/19, indicated R5 was admitted to the facility on 7/11/19, with initial diagnoses of weakness and repeated falls. R5's Diagnosis Report updated 12/13/21, added the diagnosis of wedge compression fracture of thoracic vertebra. R5's Quarterly Minimum Data Set (MDS) assessment dated 10/13/21, indicated R5 scored 9 of 15 on the brief interview for mental status (BIMS) which signifies moderate impaired cognition, and functional status identifying R5 needing extensive assistance with bed mobility, transferring, locomotion, dressing, toileting, personal hygiene, and walking did not occur. R5's Care Plan falls focus area last revised 11/18/20, identified R5 as moderate risk for falls. Fall prevention interventions included: 7/29/19, anticipate and meet R5's needs; 7/29/19, be sure call light is within reach and encourage to use; 7/29/19, ensure R5 is wearing appropriate footwear; 7/29/19, follow facility fall protocol; 7/29/19, physical therapy to evaluate and treat as ordered/as needed; and 11/18/20, requires assist of one for all transfers and has a history of self-transferring. A Fall Risk Assessment dated 12/17/21, indicated R5 scored 17, meaning at high risk for falls.	2 830		

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2 830	Continued From page 4 Document review indicated R5 had the following falls: On 09/19/21, at 6:10 p.m. staff were notified by another resident that R5 was yelling and concerned he may have fallen. Staff responded and found R5 sitting on the floor next to his bed and wheelchair. R5 stated he was trying to go to the bathroom. R5 sustained a skin tear on his left elbow. The incident report noted and fall assessement was completed and fall prevention interventions of ensure call light, cell phone, and wheelchair are within reach. However, R5's care plan was reviewed and lacked evidence the fall interventions were added and implemented post fall. The incident report further documented that R5 has had seven falls since his admission on 7/11/19. On 12/04/21, at 9:00 p.m. resident activated his call light to summon help because he had fallen while trying to go to the bathroom. Staff found R5 sitting on the floor between his bed and wheelchair. R5 did not sustain an injury. The incident report documented fall assessment was completed and fall prevention interventions of ensure call light is within reach, wear appropriate footwear, and to add offer toilet every two hours at night if awake. R5's care plan was reviewed and lacked evidence the new fall intervention was added and implemented post fall. The incident report further documented that R5 has had eight falls since his admission on 7/11/19. On 12/05/21, at 5:00 p.m. staff performing bed checks found R5 lying on the floor in the corner of the room. R5 stated he did not know what he was doing but maybe going to the bathroom. R5 complained of left rib pain. The incident report documented a fall assessment was completed but lacked evidence fall interventions were	2 830		

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2 830	Continued From page 5	2 830		

developed or implemented to reduce the likelihood of future falls for R5 post fall.

On 12/10/21, at 11:45 a.m. staff passing by R5's room heard him yelling for help. R5 was found sitting on the floor next to his bed. R5 stated no one pays attention to him and ignores his cries for help. The incident report documented no injuries. The Post Fall Assessment dated 12/13/21, documented the fall resulted in a fracture and that the care plan was reviewed. Hospital discharge summary dated 12/10/21, diagnosed R5 with T8-T9 thoracic compression fractures. The hospital summary also documented that R5 had fallen out of bed on three occasions. The incident report documented a fall assessment was completed lacked evidence fall intervention were developed or implemented to reduce the likelihood of future falls for R5 post fall.

On 12/14/21, at 4:50 p.m. R5 was found sitting on the floor holding onto the mobile table. The incident report documented R5 did not have any injuries. The 24-Hour Post Fall Assessment documented that R5 is at risk for further falls due to restless behavior and inability to make his needs known. The incident report lacked evidence fall intervention were developed or implemented to reduce the likelihood of future falls for R5 post fall.

On 12/16/21, at 10:09 a.m. R5 was observed being wheeled to his room from the dining room. R5 was unable to hold his feet up and staff were observed frequently stopping to let the resident rest. R5 was leaning over to his left side with the arm rest holding him up.

During an interview on 12/16/21, at 10:01 a.m. R5 stated he is not doing very well. He stated he was

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2 830	Continued From page 6 in constant pain from the fall and could not get comfortable. During the interview R5 was observed to hold his left side and was continually rolling from side to side and attempting to sit up. R5 stated he just could not find a comfortable position. R5 stated he received pain medication, but it barely helped alleviate the pain. R5 further stated he is so weak that he could not walk and was only able to pivot transfer. R5 stated he knows he should not transfer by himself, but it takes too long for staff to respond to his call light. During a family interview on 12/13/21, at 9:00 a.m. the family stated they had safety concerns with R5 being discharged from the hospital to the nursing home because of the multiple falls R5 had sustained. Two members of the family FM-(A) and FM-(B) met with assistant director of nursing (ADON) and registered nurse (RN)-B. FM-A and FM-B questioned what the facility was going to do for safety and how to prevent another fall. ADON and RN-B stated they will put the bed in the lowest position, placed a fall mat next to the bed, and will start performing 30-minute safety checks. FM-A and FM-B stated R5 sustained a fall at the facility approximately a year ago and now R5 had another back injury. FM-A and FM-B also stated that R5 is now on hospice care due to his thoracic compression fractures. During an interview on 12/16/21, at 10:16 a.m. NA-B stated NAs do not fill out incident reports or have access to view them; only nursing staff complete the forms and have access to them. NA-B stated that R5's safety interventions are in POC and have not changed. NA-B further stated, when a fall prevention intervention is added in the care plan, it is linked to their Kardex (Point of Care) and they receive a notification that a new responsibility or intervention has been added.	2 830		

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2 830	Continued From page 7 NA-B stated she was not unsure what R5's fall interventions were previous to his hospital stay. During an interview on 12/16/21, 12:10 p.m. licensed practical nurse (LPN)-A stated floor nursing staff enter new fall prevention interventions on the Falls Assessment and the CCC enters them into the care plan. LPN-A stated she was unsure if there were any changes in the care plan for R5 and she was not aware of fall interventions for him previous to his return from the hospital. R3's Face Sheet dated 7/24/17, indicated R3 was admitted to the facility on 7/24/17. R3's Diagnosis Report dated 7/24/17, indicated R3 diagnosis included Alzheimer's disease, dementia, anxiety, restless and agitation, and history of falling. R3's Quarterly MDS assessment dated 10/22/21, indicated R3 scored 3 of 15 on the BIMS assessment, signifying R3 as severely impaired cognition; physical behaviors symptoms towards others, such as hitting, kicking, or pushing; uses a walker for mobility; and requires extensive assistance with dressing, toileting, and personal hygiene. R3's Care Plan, falls focus area was last revised 4/10/18. Fall prevention interventions included: R3 requires supervision with ambulation, keep room and pathway free of clutter, may walk around in bare feet, and WanderGuard placed. A Fall Risk Assessment dated 11/05/21, indicated R3 scored 14, meaning at moderate risk for falls. Record review revealed R3's discharged to	2 830		

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2 830	Continued From page 8 another nursing facility on 11/29/21. Document review indicated R3 had the following falls: On 9/21/21, at 7:45 a.m. R3 was found on the floor next to her bed. The walker was in the bathroom and there was water on the floor as well as clothes all over her room. R3 did not sustain an injury. Documentation indicated R3 has had sixteen falls since her admission on 7/24/17. The incident report documented fall prevention interventions of anticipate R3's needs, be sure call light is within reach, provide a safe environment with floors free from spills and clutter, and ensure walker is always within reach. R5's care plan was reviewed and lacked evidence the new fall interventions were added and implemented post fall. On 11/01/21, at 5:30 a.m. staff heard a thud from R3's room and upon investigation, R3 was found lying on the floor by her bed. During an assessment for injuries, it was found that R3 sustained a 0.25 cm x 7.0 cm laceration to the back of her head. R3 was taken to the nurse's station and a cold pack was applied to the wound. The incident report lacked evidence of new fall interventions but noted interventions from fall on 9/21/21 were not care planned post fall of anticipate R3's needs, be sure call light is within reach, provide a safe environment with floors free from spills and clutter, and ensure walker is always within reach. R3's care plan was reviewed and lacked evidence the fall interventions were added and implemented post fall for 11/1/21 fall as well. During an interview on 12/16/21, 10:27 a.m. ADON stated the new interventions that were placed for R5 include keeping the bed in lowest	2 830		

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2 830	Continued From page 9	2 830		

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During an interview on 12/16/21, 11:01 a.m. CCC-A stated she is just becoming aware there is a system issue of who enters fall prevention interventions in the care plan. CCC-A stated it was the floor nurse's responsibility to enter interventions. CCC-A stated the inter disciplinary team (IDT) only briefly discusses falls during the morning stand-up meeting and new interventions are not discussed. CCC-A further stated the facility does not have a falls prevention committee and QAPI is not tracking if current fall prevention interventions are working or should be updated/revised.

During an interview on 12/16/21, at 9:46 a.m. nursing assistant (NA)-A stated fall prevention interventions are in the Point of Care (POC) section of PointClickCare (PCC) electronic medical record. When a fall prevention intervention is added in the care plan, it is linked to their Kardex (Point of Care) and NA's receive a notification that a new intervention has been added. NA-A explained there have been no new fall prevention interventions because NA's would have been notified that one has been added. NA-A further stated that NAs do not fill out fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	C 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 incident reports or have access to look at them. This prohibit NA's from viewing fall prevention interventions and being able to implement them. NA state she was unware of R3's fall interventions were previous to her demission or what R5's interventions were previous to his hospital stay. The facility's policy entitled Falls, last revised 10/21, directed the charge nurse, CCC, or the DON/ADON complete the Fall Root Cause Analysis, investigation, provide intervention from the root cause analysis, and CCC or DON/ADON to update the care plan with the intervention. It was found that the facility is not following the Falls policy. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		