DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 28, 2025

Administrator
Madison Healthcare Services
900 SECOND AVENUE
MADISON, MN 56256

RE: CCN: 245382
Cycle Start Date: June 4, 2025

Dear Administrator:

On July 17, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

Administrator
Madison Healthcare Services
900 SECOND AVENUE
MADISON, MN 56256

Re: Reinspection Results
Event ID: PFUX11

Dear Administrator:

On July 17, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 4, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2025

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: June 4, 2025

Dear Administrator:

On June 4, 2025, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html**

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2025

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: PFUX11

Dear Administrator:

The above facility was surveyed on June 3, 2025 through June 4, 2025 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 06/04/2025

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 000	INITIAL COMMENTS On 6/3/25 to 6/4/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53826167C (MN00113506) with a deficiency issued at F558, F658 and F684. H53826309C (MN00113602) with a deficiency issued at F558, F658 and F684. Use this statement if deficiencies are issued on this survey 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		7/11/25

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

Electronically Signed | 06/25/2025

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 558	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure the call light was accessible for 1 of 1 residents (R1) who was reviewed for call light placement. R1's admission Minimum Data Set (MDS) dated 4/4/25, indicated R1 was cognitively intact and had diagnoses that included heart failure and a hip fracture. Identified R1 required maximum assistance with bed mobility, transfers and toileting. R1's care plan dated, 3/26/25, directed staff to make sure R1's call light was within reach and to encourage R1 to use the call light. During an continuous observation on 6/4/25 at 7:10 a.m. to 8:21 a.m., R1 was sitting in her wheelchair eating breakfast. R1 received her breakfast tray at 7:20 a.m., nursing assistant (NA)-A cut up R1's french toast and applied syrup. NA-A provided R1 half of a banana on her tray also. R1 began to eat her meal. R1 completed eating her meal at 7:54 a.m. R1 began looking for her call light. R1 stated she was unable to find her call light. R1 further stated staff did not always provide her with her call light when she was sitting in her wheelchair. R1 indicated she would just have to wait for staff to come back in her room to help her. R1's call light was attached to her bedside railing and R1 was unable to reach her call light. R1 continued to wait for staff to come to her room to assist her. During an observation on 6/4/25 at 8:20 a.m., NA-A and NA-B entered R1's room to assist her. NA-A grabbed a washcloth and ran it under warm water and handed the wash cloth to R1. R1 washed her face and hands and gave the	F 558	"Based on observation, interview, and document review, the facility failed to ensure the call light was accessible for 1 of 1 residents (R1) who was reviewed for call light placement. RCA and contributing factors to this deficient practice- 1) The facility failed to ensure the call light was accessible for 1 of 1 residents who was reviewed for call light placement. Corrective action will be accomplished immediately or as indicated by the following: 1. R1 will be provided with two call lights in the room and a sign attached to R1's exiting door stating, "Ensure call light is within reach; Across chest while in bed, right handle while in wheelchair, right side while in recliner, follow resident's requests" by 6/24/2025. 2. DON, RN MDS Coordinator, RN Clinical Care Coordinator, and Scheduler will alternate performing call light audits on 5 residents 3x a week x 2 week, then 1x a week until 100% for two months. R1 will repeatedly be one of the five residents audited. 3. The DON will report audit results at the facility's monthly QAPI meeting until the goal has been achieved. Each auditor will provide on the spot correction and education to nursing staff if findings of a call light not within reach occur. 4. A communication was Posted in PointClickCare to all nursing staff reminding them of the facility policy that states, 'When resident is in bed or confined to a chair, call light will be within	

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	245382	A. BUILDING _____ B. WING _____	C 06/04/2025

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 558	Continued From page 2 washcloth back to NA-A. NA-A and NA-B assisted R1 to the restroom. During an interview on 6/3/25 at 5:20 p.m., R1 stated staff often forgot to give her the call light when she was sitting in her wheelchair. R1 indicated she did not have good eye sight and was not able to find the call light if it was not placed on her wheelchair handle. R1 stated at times she would need to yell out for help because she did not have her call light. During an interview on 6/3/25 at 6:00 p.m., family member (FM)-A and FM-B revealed they have had to provide R1 with her call light on several occasions because staff did not provide the call light to R1. FM-A indicated R1's call light was to be placed across R1's chest when laying in bed and attached to the right handle of R1's wheelchair when R1 was sitting in her wheelchair. FM-A further indicated there were several occasions where R1 did not have her call light for extended periods of time. During a follow-up interview on 6/4/25 at 11:28 a.m., R1 was laying in her bed and her call light was across her chest. FM-A indicated FM-A placed R1's call light on R1's chest after staff assisted R1 to bed. FM-A revealed staff did not provide R1 with her call light after R1 was in bed. During an interview on 6/4/25 at 11:52 a.m., NA-A and NA-B stated they were not aware they did not provide R1 with her call light during breakfast. NA-A and NA-B stated they thought they had provided R1 with her call light after getting her up in her wheelchair for breakfast. During an interview on 6/4/25 at 2:08 p.m.,	F 558	easy reach of the resident' on 6/22/2025. 5. Medical Director offered input and is agreeable to this corrective action based on verbal conversation with DON on 6/23/2025. 6. Care center staff, including nursing, administrator, maintenance, housekeeping, social services, activities, dietary and chaplaincy will be educated on the Call Light- Answering of Policy, as well as the expectation that all staff are to ensure any bedridden or chair ridden resident has their call light within reach prior to exiting the resident's room. 7. This plan was put in place and completed by 7/11/2025.	

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F 558	Continued From page 3 director of nursing (DON) was unaware R1 did not have her call light for one hour and 11 minutes. DON stated it would be her expectation to have a call light within reach for residents. Facility policy titled call light - answering of revised 6/2025, when resident was in bed or confined to a chair call light would be within easy reach of resident.	F 558		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a process in place to ensure resident provider recommendations were followed up on in a timely manner for 1 of 1 residents (R1). Findings include: R1's admission Minimum Data Set (MDS) dated 4/4/25, indicated R1 was cognitively intact and had diagnoses that included heart failure and a hip fracture. Identified R1 required maximum assistance with bed mobility, transfers and toileting. R1's Care Area Assessment (CAA) for nutritional status dated 4/8/25, identified contractures, functional limitation in range of motion, partial or total loss of arm movement that could affect her	F 658	"Based on observation, interview, and record review, the facility failed to have a process in place to ensure resident provider recommendations were followed up on in a timely manner for 1 of 1 residents (R1)." RCA and contributing factors to this deficient practice- 1) The facility failed to ensure resident provider recommendations were followed up on in a timely manner for 1 of 1 residents. Corrective action will be accomplished immediately or as indicated by the following: 1. The resident's provider was messaged via Epic on 6/6/25 by RN Clinical Care Coordinator. Further recommendations included: Biotene Dry Mouth Oral Rinse. OTC. Spray or gel;	7/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 4 nutritional status. R1's care plan dated 3/26/25, indicated R1 would maintain adequate nutritional status. Review of R1's progress notes dated 4/17/25 to 6/3/25, identified R1's mouth was very dry and that it may contribute to the decay and discomfort. Please help with brushing her teeth two x/day- eliminating the plague in her mouth was very important. Have medical doctor (MD) look into options to help resident within her xerostomia (commonly known as dry mouth, the sensation of not having enough saliva). R1's signed physicians orders dated 5/21/25, lacked documentation R1 received any medication for xerostomia. During an interview on 6/3/25 at 5:20 p.m., R1 stated her mouth was very dry and indicated it was difficult to swallow at times due to her dry mouth. During an interview on 6/3/25 at 6:00 p.m., family member (FM)-A and FM-B revealed R1 had a dry mouth frequently and R1 had not received any medication to help with her dry mouth. FM-A stated R1 had seen the dentist and it was recommended R1 receive something from her primary provider for her dry mouth. During an interview on 6/4/25 at 4:35 p.m., registered nurse (RN)-A stated the facility had not talked to R1's provider about ordering something for R1's dry mouth per the dentist recommendations on 5/24/25 at 10:21 a.m. During an interview on 6/4/25 at 2:08 p.m.,	F 658	patient/family preference. Resident was offered the recommendations, however, declined the pharmacological intervention and the provider was updated accordingly. 2. The RN Clinical Care Coordinator (RN MDS Coordinator or DON in RN CCC's absence) will perform routine audits after each dental and vision appointment to ensure all recommendations are followed up on within 48 hours of the appointment, unless otherwise indicated by the dentist or optometrist. Audits are to be performed for each resident until the goal of 100% of all recommendations being followed up on and documented in PointClickCare in a timely manner is completed for six months. 3. The RN Clinical Care Coordinator will report findings each month to DON, in which the DON will report at the facility's monthly QAPI meeting until the goal is achieved. 4. Medical Director offered input and is agreeable to this corrective action based on verbal conversation with DON on 6/23/2025. 5. Care center LPN's and RN's will be educated on the expectation that all recommendations from dental or optometry will be communicated with the primary care provider ASAP (at maximum of 48 hours) either via telephone, person, or message. 6. This plan was put in place and completed on 7/11/2025.	

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F 658	Continued From page 5 director of nursing (DON) was unaware R1 had received recommendations from the dentist. DON stated nursing staff should have contacted R1's provider to get something ordered. DON further stated it was her expectation that staff would be in contact with the provider when recommendations were made. A facility policy notifying the provider was requested but facility stated they did not have a specific policy on notifying the provider.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care for 1 of 1 residents (R1) reviewed for wound care. Findings include: R1's admission Minimum Data Set (MDS) dated 4/4/25, indicated R1 was cognitively intact and had diagnoses that included heart failure and a hip fracture. Identified R1 required maximum assistance with bed mobility, transfers and toileting.	F 684	"Based on interview and document review the facility failed to perform ongoing monitoring and wound care for 1 of 1 residents (R1) reviewed for wound care." RCA and contributing factors to this deficient practice- 1)The facility failed perform ongoing monitoring and wound care for 1 of 1 residents reviewed for wound care. Corrective action will be accomplished immediately or as indicated by the following:	7/11/25

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MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

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F 684	Continued From page 6 R1's care plan dated 3/26/25, lacked documentation about R1's wound care. R1's signed physicians orders dated 5/21/25, identified Mepilex dressing to left hip change every two to three days, ok to shower with on one time a day. R1's signed physician's note dated 5/21/25, identified R1 had a surgical incision of the left hip that was open and had a small amount of drainage. Further identified nursing staff had been placing a Mepilex dressing over that area. Review of R1's electronic health record (EHR) skin observation tool from 3/26/25 to 6/1/25, revealed the following: 3/26/25, left thigh front surgical incision. 4/16/25, incision to left hip, staples intact. 4/23/25, left trochanter (hip), surgical incision 11 centimeters (cm) X 0.1 cm. 5/1/25, continues with incision to left hip. 5/7/25, continues to have incision on left hip. 5/14/25, nothing about hip. 5/21/25, surgical would to left hip healed at this time. 6/1/25, no skin concerns noted. R1's Electronic Treatment Administration Record (ETAR) dated 4/1/25 to 6/5/25, identified R1 received dressing changes every three days. During an interview on 6/4/25 at 4:35 p.m., registered nurse (RN)-A indicated R1 saw the provider on 5/21/25, and the provider stated the dressing could be left off because the surgical incision only had a small pink mark. RN-A further indicated three days later R1 was sent to the	F 684	1. DON performed chart review and the dressing was changed on 6/2/2025 by LPN. Order from discharge from hospital on 5/28/2025 states to change dressing every 3-5 days or more often if saturated. Order in PointClickCare dated 5/30/2025 states to change dressing every Monday and Thursday and as needed. 2. Education was provided to the staff involved in the lack of wound assessment/monitoring and documentation related to R1's surgical wound and also included the review of the facility's Wound Assessment and Care Policy on 6/23/2025. 3. RN Clinical care Coordinator (RN MDS Coordinator or DON in RN CCC's absence) will review all admission and readmission orders to ensure all wound and/or skin issues/concerns have dressing orders and/or implement according to policy. 4. RN Clinical Care Coordinator will keep an ongoing record of resident wounds and report on each week until healed at IDT with no end date of reporting. 5. RN Clinical Care Coordinator will provide a summary of wounds, including interventions, and report each month to DON, in which the DON will report at the facility's monthly QAPI meeting for three months, unless otherwise specified if issues/concerns arise. 6. Medical Director offered input and is agreeable to this corrective action based on verbal conversation with DON on 6/23/2025. 7. Care center LPN's and RN's will be	

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F 684	Continued From page 7 hospital due to an abscess that was actively draining from the left hip and R1 needed antibiotics. RN-A stated RN-B looked at the wound on 5/30/25, when R1 returned from the hospital. R1's EMR lacked documentation the would had been assessed since R1 came back from the hospital. During an observation on 6/4/25 at 8:38 a.m., nursing assistant (NA)-A and NA-B were done giving R1 a bath. Licensed practical nurse (LPN)-A entered R1's bathroom to assess R1's wound. LPN-A put on a pair of gloves and removed the undated Mepilex dressing from R1's left thigh. LPN-A inspected the surgical wound and noted the wound was intact with only a small pin point opening at the top of the wound. LPN-A removed her gloves, left the room and returned with a new Mepilex dressing. LPN-A put on a new pair of gloves and applied the Mepilex dressing over the surgical would. LPN-A removed gloves and stated she was going to chart the wound later. During a follow-up in interview on 6/4/25 at 9:30 a.m., RN-A stated the orders for the Mepilex dressing were received from Prairie Lakes clinic in South Dakota. RN-A stated when R1 had the wound vacuum removed, the facility received orders to apply a Mepilex dressing over the surgical wound from the clinic. During an interview on 6/4/25 10:20 a.m., family member (FM)-A stated the dressing had not been changed since R1 returned from the hospital on 5/30/25. A call was placed to R1's medical provider, however no return call was received.	F 684	educated on the facility's Wound Assessment and Care Policy, as well as the expectation of wound care orders being addressed appropriately with treatment and follow up. 8. This plan was put in place and completed by 7/11/2025.	

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F 684	Continued From page 8 During an interview on 6/4/25 at 2:08 p.m., director of nursing (DON) stated she was unaware staff had not changed the Mepilex dressing since returning from the hospital. DON indicated she would expect nursing staff to properly assess the surgical wound and follow providers orders regarding dressing changes. DON further stated it was important to change the dressing following providers orders to prevent a further infection. The facility policy wound assessment and care revised 12/2023, identified all residents would have a head-to-toe skin assessment completed upon admission and readmission which will be performed by the Clinical Care Coordinator (CCC) or admitting RN. Skin assessments would be at least weekly thereafter. Date and time first assessed. Document if present on admission. Wound classification (ulcer, surgical wound , etc.). Descriptive location. Measurement: measure all wounds in centimeters using a paper ruler and cotton-tipped applicator as needed. Measure in this order: Length x Width x Depth.	F 684		

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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: On 6/3/25 to 6/4/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53826167C (MN00113506) with a licensing order issued at 1810. H53826309C (MN00113602) with a licensing order issued at 1810. 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 evidenced by. "Following the surveyors 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 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	2 000		

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2 000	Continued From page 2 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		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light was accessible for 1 of 1 residents (R1) who was reviewed for call light placement. R1's admission Minimum Data Set (MDS) dated 4/4/25, indicated R1 was cognitively intact and had diagnoses that included heart failure and a hip fracture. Identified R1 required maximum assistance with bed mobility, transfers and toileting.	21810	corrected	6/24/25

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21810	Continued From page 3 R1's care plan dated, 3/26/25, directed staff to make sure R1's call light was within reach and to encourage R1 to use the call light. During an continuous observation on 6/4/25 at 7:10 a.m. to 8:21 a.m., R1 was sitting in her wheelchair eating breakfast. R1 received her breakfast tray at 7:20 a.m., nursing assistant (NA)-A cut up R1's french toast and applied syrup. NA-A provided R1 half of a banana on her tray also. R1 began to eat her meal. R1 completed eating her meal at 7:54 a.m. R1 began looking for her call light. R1 stated she was unable to find her call light. R1 further stated staff did not always provide her with her call light when she was sitting in her wheelchair. R1 indicated she would just have to wait for staff to come back in her room to help her. R1's call light was attached to her bedside railing and R1 was unable to reach her call light. R1 continued to wait for staff to come to her room to assist her. During an observation on 6/4/25 at 8:20 a.m., NA-A and NA-B entered R1's room to assist her. NA-A grabbed a washcloth and ran it under warm water and handed the wash cloth to R1. R1 washed her face and hands and gave the washcloth back to NA-A. NA-A and NA-B assisted R1 to the restroom. During an interview on 6/3/25 at 5:20 p.m., R1 stated staff often forgot to give her the call light when she was sitting in her wheelchair. R1 indicated she did not have good eye sight and was not able to find the call light if it was not placed on her wheelchair handle. R1 stated at times she would need to yell out for help because she did not have her call light. During an interview on 6/3/25 at 6:00 p.m., family	21810		

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21810	Continued From page 4 member (FM)-A and FM-B revealed they have had to provide R1 with her call light on several occasions because staff did not provide the call light to R1. FM-A indicated R1's call light was to be placed across R1's chest when laying in bed and attached to the right handle of R1's wheelchair when R1 was sitting in her wheelchair. FM-A further indicated there were several occasions where R1 did not have her call light for extended periods of time. During a follow-up interview on 6/4/25 at 11:28 a.m., R1 was laying in her bed and her call light was across her chest. FM-A indicated FM-A placed R1's call light on R1's chest after staff assisted R1 to bed. FM-A revealed staff did not provide R1 with her call light after R1 was in bed. During an interview on 6/4/25 at 11:52 a.m., NA-A and NA-B stated they were not aware they did not provide R1 with her call light during breakfast. NA-A and NA-B stated they thought they had provided R1 with her call light after getting her up in her wheelchair for breakfast. During an interview on 6/4/25 at 2:08 p.m., director of nursing (DON) was unaware R1 did not have her call light for one hour and 11 minutes. DON stated it would be her expectation to have a call light within reach for residents. Facility policy titled call light - answering of revised 6/2025, when resident was in bed or confined to a chair call light would be within easy reach of resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have a call	21810		

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21810	Continued From page 5 light within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		