



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 4, 2024

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: November 17, 2023

Dear Administrator:

On December 28, 2023, 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 4, 2024

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: Reinspection Results
Event ID: KM0F12

Dear Administrator:

On December 28, 2023 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 November 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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December 5, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: November 17, 2023

Dear Administrator:

On November 17, 2023, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 17, 2024 (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 May 17, 2024 (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) / 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/lrc_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.

Madison Healthcare Services

December 5, 2023

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: KM0F11

Dear Administrator:

The above facility was surveyed on November 16, 2023 through November 17, 2023 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.

Madison Healthcare Services

December 5, 2023

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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:

**Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

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.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/17/2023
NAME OF PROVIDER OR SUPPLIER MADISON HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 11/16/23 and 11/17/23, 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. H53827138C (MN00091187), H53827225C (MN00097351), H53827226C (MN00096307) and H53827139C (MN00098417). Deficient practice was identified related to incidental finding F656. 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		12/26/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/07/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	<p>Continued From page 1</p> <p>needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document</p>	F 656	F656 SS=D Develop/Implement	

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F 656	<p>Continued From page 2</p> <p>review interview the facility failed to follow the care plan for a fall intervention to mitigate the risk for falls or falls with serious injury for 1 of 6 residents (R1) who had history of falls with injury.</p> <p>Findings include</p> <p>R1's annual Minimal Data Set (MDS) dated 8/31/23, identified R1 had diagnosis of Alzheimer's disease. R1 required limited assist of one staff with two wheeled walker for ambulation and required supervision with two wheeled walker for transfers. R1 had no falls.</p> <p>R1's Fall Analysis Risk assessment dated 10/9/23, indicated R1 had an unwitnessed fall when she self-transferred out of bed, got dizzy, and fell to the floor. The fall analysis identified R1 was dizzy, did not always use her walker, and was not wearing shoes or gripper socks. New fall interventions included adding a bed alarm.</p> <p>Review of R1's fall care plan dated 9/22/21, indicated R1 was at risk for falls due to impairment of mobility and poor safety awareness. The care plan included the intervention for bed alarm dated 10/9/23.</p> <p>R1's fall incident report dated 10/11/23, identified R1 had an unwitnessed fall when she self-transferred out of bed. The report indicated the bed alarm had sounded.</p> <p>R1's fall incident report dated 11/9/23, identified R1 had an unwitnessed fall after a self-transfer. The report did not identify if the bed alarm had been functioning or was in place at the time of R1's fall.</p>	F 656	<p>Comprehensive Care Plan Directed Plan of Correction (DPOC)</p> <p>Comprehensive Care Plans</p> <p>1. R1's annual Minimum Data Set (MDS) dated 8/31/23, identified R1 had diagnosis of Alzheimer's disease. R1 required limited-assist of one staff with two-wheeled walker for ambulation and required supervision with two-wheeled walker for transfers. R1 had no falls. R1's Fall Analysis Risk assessment dated 10/9/23, indicated R1 had an unwitnessed fall when she self-transferred out of bed, got dizzy, and fell to the floor. The fall analysis identified R1 was dizzy, did not always use her walker, and was not wearing shoes or gripper socks. New fall interventions included adding a bed alarm. Review of R1's fall care plan dated 9/22/21, indicated R1 was at risk for falls due to impairment of mobility and poor safety awareness. The care plan included the intervention for bed alarm dated 10/9/23. R1's fall incident report dated 10/11/23, identified R1 had an unwitnessed fall when she self-transferred out of bed. The report indicated the bed alarm had sound. R1's fall incident report dated 11/9/23, identified R1 had an unwitnessed fall after a self-transfer. The report did not identify if the bed alarm had been functioning or was in place at the time of R1's fall. During an observation on 11/17/23 at 8:25 a.m., R1 was lying in bed with eyes closed when hairdresser entered R1's room and told R1 it was time to get her hair done. R1 stood up from her bed; no alarm sounded, and the call light was not activated. R1 exited her</p>	

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F 656	<p>Continued From page 3</p> <p>During an observation on 11/17/23 at 8:25 a.m., R1 was lying in bed with eyes closed when hairdresser entered R1's room and told R1 it was time to get her hair done. R1 stood up from her bed; no alarm sounded and the call light was not activated. R1 exited her room and followed the hairdresser down the hallway, passing licensed practical nurse (LPN-A), who then followed R1 to the beauty shop.</p> <p>During an interview on 10/17/23 at 9:06 a.m., nursing assistant (NA)-M, indicated bed alarms were activated when a resident got off the bed and call light goes off with a special flash and sound at the nurses stations. Staff were to respond to that room right away to prevent the fall.</p> <p>During an interview on 10/17/23 at 9:41 a.m., NA-A stated that the bed alarms were connected to the call light system that would alert staff by a special light. Staff were supposed to respond right away to those lights to prevent falls.</p> <p>During an interview on 11/17/23 at 10:00 a.m., LPN-A reviewed R1's care plan and verified R1 required a bed alarm. LPN-A did not know why the bed alarm had not sounded nor activate the call light at 8:25 a.m. when R1 got out of bed.</p> <p>During an interview on 11/17/23 at 10:08 a.m., registered nurse (RN)-A reviewed R1's care plan and went to R1's room. RN-A was unable to locate the bed alarm device anywhere on or around R1's bed. RN-A stated she was not aware of how long the alarm had not been on the bed.</p> <p>During an interview on 11/17/23 at 10:46 a.m. director of nursing (DON) stated bed alarms alert</p>	F 656	<p>room and followed the hairdresser down the hallway, passing licensed practical nurse (LPN-A), who then followed R1 to the beauty shop. During an interview on 11/17/23 at 9:06 a.m., nursing assistant, NA-M, indicated bed alarms were activated when a resident got off the bed and call light goes off with a special flash and sound at the nurse's stations. Staff were to respond to that room right away to prevent the falls. During an interview on 11/17/23 at 9:41 a.m., NA-A stated that the bed alarms were connected to the call light system that would alert staff by a special light. Staff were supposed to respond right away to those lights to prevent falls. During an interview on 11/17/23 at 10:00 a.m., LPN-A reviewed R1's care plan and verified R1 required a bed alarm. LPN-A did not know why the bed alarm had not sounded nor activate the call light at 8:25a.m. when R1 got out of bed. During an interview on 11/17/23 at 10:08 a.m., registered nurse (RN)-A reviewed R1's care plan and went to R1's room. RN-A was unable to locate the bed alarm device anywhere on or around R1's room. RN-A was unable to locate the bed alarm device anywhere on or around R1's bed. RN-A stated she was not aware of how long the alarm had not been on the bed. During an interview on 11/17/23 at 10:46 a.m., director of nursing (DON) stated bed alarms alert staff when residents were moving or getting out of bed. DON reviewed R1's care plan and verified R1 was supposed to have an alarm, DON's stated expectation staff were to follow care plans</p>	

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F 656	<p>Continued From page 4</p> <p>staff when residents were moving or getting out of bed. DON reviewed R1's care plan and verified R1 was supposed to have an alarm, DON's stated expectation staff were to follow care plans for all residents. DON was not aware if an alarm had been in place on 11/9/23 when R1 last fell.</p> <p>Review of the facility's policy entitled Care Plan-Care Center dated 03/2023, indicated all resident would have an individualized plan of care addressing problems and needs identified in the comprehensive assessment. The plan would include problems, goals and interventions to meet the individualized needs of each resident.</p>	F 656	<p>for all residents. DON was not aware if an alarm had been in place on 11/9/23 when R1 last fell. Review of the facility's policy entitled Care Plan- Care Center dated 03/2023, indicated all resident would have an individualized plan of care addressing problems and needs identified in the comprehensive assessment. The plan would include problems, goals and interventions to meet the individualized needs of each resident.</p> <p>RCA and contributing factors to this deficient practice- 1) Nursing staff were not routinely checking to ensure alarms were in place once implemented and placed in the care plan.</p> <p>Corrective action will include the following:</p> <ul style="list-style-type: none"> • Immediate re-implementation of a bed alarm for R1 on 11/17/23. • Orders in each residents Treatment Administration Record (TAR) for nurses/TMAs to ensure alarms are in place and functioning properly each shift for all residents requiring alarms for safety, both now and going forward with new admissions and/or current residents requiring this particular fall intervention. • The DON will complete weekly audits on the TAR's pertaining to the residents who have alarms as part of their care plan to ensure nursing is checking placement and function of alarms until completion reaches 100% for three months. Audits will be presented monthly at QAPI. • the DON will be monitoring three days a week to ensure alarms are in place and working properly until completion reaches 	

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F 656	Continued From page 5	F 656	100% for three months. Audits will be presented monthly at QAPI meetings. • All nursing staff will be educated/review the following facility policies: Care Plans- Care Center, Falls, and Safe Patient Handling by 12/26/23, complete with a post-test to ensure completion of review and comprehension of information.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00329	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2023
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NAME OF PROVIDER OR SUPPLIER MADISON HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256
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(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
2 565	<p>MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use</p> <p>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review interview the facility failed to follow the care plan for a fall intervention to mitigate the risk for falls or falls with serious injury for 1 of 6 residents (R1) who had history of falls with injury.</p> <p>Findings include</p> <p>R1's annual Minimal Data Set (MDS) dated 8/31/23, identified R1 had diagnosis of Alzheimer's disease. R1 required limited assist of one staff with two wheeled walker for ambulation and required supervision with two wheeled walker for transfers. R1 had no falls.</p> <p>R1's Fall Analysis Risk assessment dated 10/9/23, indicated R1 had an unwitnessed fall when she self-transferred out of bed, got dizzy, and fell to the floor. The fall analysis identified R1 was dizzy, did not always use her walker, and was not wearing shoes or gripper socks. New fall interventions included adding a bed alarm.</p> <p>Review of R1's fall care plan dated 9/22/21, indicated R1 was at risk for falls due to impairment of mobility and poor safety awareness. The care plan included the intervention for bed alarm dated 10/9/23.</p>	2 565	Corrected	12/26/23

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/07/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00329	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2023
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NAME OF PROVIDER OR SUPPLIER MADISON HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256
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2 565	<p>Continued From page 1</p> <p>R1's fall incident report dated 10/11/23, identified R1 had an unwitnessed fall when she self-transferred out of bed. The report indicated the bed alarm had sounded.</p> <p>R1's fall incident report dated 11/9/23, identified R1 had an unwitnessed fall after a self-transfer. The report did not identify if the bed alarm had been functioning or was in place at the time of R1's fall.</p> <p>During an observation on 11/17/23 at 8:25 a.m., R1 was lying in bed with eyes closed when hairdresser entered R1's room and told R1 it was time to get her hair done. R1 stood up from her bed; no alarm sounded and the call light was not activated. R1 exited her room and followed the hairdresser down the hallway, passing licensed practical nurse (LPN-A), who then followed R1 to the beauty shop.</p> <p>During an interview on 10/17/23 at 9:06 a.m., nursing assistant (NA)-M, indicated bed alarms were activated when a resident got off the bed and call light goes off with a special flash and sound at the nurses stations. Staff were to respond to that room right away to prevent the fall.</p> <p>During an interview on 10/17/23 at 9:41 a.m., NA-A stated that the bed alarms were connected to the call light system that would alert staff by a special light. Staff were supposed to respond right away to those lights to prevent falls.</p> <p>During an interview on 11/17/23 at 10:00 a.m., LPN-A reviewed R1's care plan and verified R1 required a bed alarm. LPN-A did not know why the bed alarm had not sounded nor activate the call light at 8:25 a.m. when R1 got out of bed.</p>	2 565		

Minnesota Department of Health

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2 565	<p>Continued From page 2</p> <p>During an interview on 11/17/23 at 10:08 a.m., registered nurse (RN)-A reviewed R1's care plan and went to R1's room. RN-A was unable to locate the bed alarm device anywhere on or around R1's bed. RN-A stated she was not aware of how long the alarm had not been on the bed.</p> <p>During an interview on 11/17/23 at 10:46 a.m. director of nursing (DON) stated bed alarms alert staff when residents were moving or getting out of bed. DON reviewed R1's care plan and verified R1 was supposed to have an alarm, DON's stated expectation staff were to follow care plans for all residents. DON was not aware if an alarm had been in place on 11/9/23 when R1 last fell.</p> <p>Review of the facility's policy entitled Care Plan-Care Center dated 03/2023, indicated all resident would have an individualized plan of care addressing problems and needs identified in the comprehensive assessment. The plan would include problems, goals and interventions to meet the individualized needs of each resident.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 565		