DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2019

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: July 29, 2019

Dear Administrator:

On September 16, 2019, the Minnesota Department(s) of Health and Public Safety, completed a Post Certification Revisit (PCR) by desk review and on September 20, 2019, we completed an on-site PCR to verify that your facility had achieved and maintained compliance. Based on the desk review and the on-site PCR, we have determined that your facility has achieved substantial compliance as of September 20, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 20, 2019 is to be rescinded as of effective October 20, 2019. (42 CFR 488.417 (b))

In our letter of August 19, 2019, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 20, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 20, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded however, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
September 9, 2019

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: Project Numbers SS5382029, H5382015C

Dear Administrator:

On August 19, 2019, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a Standard survey, completed on August 1, 2019. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 23, 2019, an abbreviated standard 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 constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby 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 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 October 20, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) from this visit is enclosed.

NURSE AIDE TRAINING PROHIBITION

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 $10,483; 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 October 20, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, the facility will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 20, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law
105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 November 1, 2019 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 1, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

cc: Licensing and Certification File

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 08/23/2019

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 From 8/22-23 2019, an abbreviated survey was completed to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5382015C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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 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 interview and document review, the facility failed to provide the correct mechanical lift	F 689	R1 was assessed by therapy immediately after returning from the	9/19/19

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

Electronically Signed | 09/16/2019

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F 689	Continued From page 1 to prevent accident hazards for 1 of 1 residents who fell from the mechanical lift and sustained a fractured femur (upper leg), resulting in actual harm. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 5/21/19, identified moderate cognitive impairment, and needed extensive staff assistance for bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene. Both verbal and physical behavior was identified 1-3 days during the assessment period, and no falls identified. The MDS identify diagnoses included dementia, history of fall with hip fracture (greater 6 months ago); and osteoporosis. R1's care plan with a initiation date of 6/13/14 and revision date of 8/23/19, listed a Focus of at risk for falls related to unaware of safety needs, need for total assist with mechanical lift for all transfers. Physically unable to bear own weight independently or walk. Interventions included: Transfer: Requires two staff and hoyer lift for all transfers in and out of bed. The EZ stand may be used for transfers to and from wheelchair to commode only. The nursing assistant care sheet (undated), Transfer: The resident requires 2-3 staff and hoyer lift for all transfers. R1 had a documented history of becoming agitated and both verbally and physically aggressive during the provision of cares. In order to promote safety for R1 and the staff providing the care, 2-3 staff persons were care planned to assist with the provision of care and transfers with the use of both the EZ stand (allows for transfer of a patient	F 689	hospital and R1□s care plan was updated as needed. All staff have been re-educated on the importance of following the care plan. NA-A and NA-B both received written warnings for not following the care plan. All residents that use the EZ stand or EZ lift have been assessed by therapy or nursing staff to assure the appropriate device is used for transferring all residents. All resident care plans have been revised as needed. A guide for staff on how each resident transfers was put in each resident□s closet and will be updated when the plan of care is changed. All residents will be assessed for transfer ability upon admission, quarterly, annually, with a significant change and as needed. A request for therapy will be initiated if needed. Training for all nursing staff was held by big stone therapy 8/26/19, 8/29/19 and 8/30/19. Education and competency testing was completed for the EZ stand and EZ lift. For the staff that did not attend this training, competency testing was performed by the DON, care coordinators or designee. For on call staff competency testing will be performed by the DON, care coordinators or designee before that staff works on the floor.	

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MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE MADISON, MN 56256**

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F 689	Continued From page 2 in a standing position) and hoyer lifts (full body lift). Review of the facility investigation of the incident dated 8/13/19, at 11:40 a.m. indicated R1 was being transferred by staff, nursing assistant (NA)-A from her wheelchair to the bed utilizing the EZ stand lift. R1 became agitated, let go of the EZ stand hand holds and began swinging at NA-A. R1 slid from the EZ stand, onto the bed and from the bed to the floor. R1 had no obvious injuries, but complained of her left shoulder and hip hurting. R1 was transferred to the Emergency Department for evaluation where she was found to have a non displaced left femur subcapital fracture. RN-A whom investigated the incident indicated the original care plan listed: Toilet Use: The resident requires one-two staff and the EZ Stand, Use commode for all toileting. Transfer: The resident requires two staff and hoyer lift for all transfers in and out of bed. The EZ Stand may be used for transfers to and from wheelchair to commode only. The investigation revealed NA-B had failed to place a lift sheet underneath R1 when she was gotten up that morning. During the subsequent interview with NA-B it was verified the EZ Stand lift had been utilized to get R1 out of bed on 8/13/19 and transfer her to the wheelchair, instead of the hoyer lift as indicated in the care plan. Both NA-A and NA-B were interviewed by RN-A and verified they had failed to follow the directions identified in the care plan for R1. The interim director of nursing (DON) was interviewed on 8/22/19, at 3:14 p.m. and verified as a result of the facility investigation it was determined NA-A and NA-B had failed to provide	F 689	There is also another mandatory training by EZ way on 9/17/19. If staff does not attend this training there will be a video and post-test that will need to be completed before returning to work on the floor. Random audits of staff following the care plan and using the right mechanical lift will be conducted by the DON, clinical care coordinators or designee, weekly x 8 weeks, then monthly x 3 months and then every other month. Staff that is not following the plan of care will be disciplined per facility policy. Summary of the audits will be shared with the QAPI committee monthly for three months and quarterly thereafter. QAPI will document this in the meeting minutes and will decide the need to continue monitoring or if this is in compliance. Responsible: DON or designee	

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F 689	Continued From page 3	F 689		

care according to the care plan for R1. As a result R1 fell and sustained a serious injury. The incident was reviewed by the licensed social worker and a report filed with the state agency. DON stated both employees received written disciplinary warnings. In addition documentation was provided and an in-service provided by the EZ Way Representative on 7/15/19 (before R1's fall out of the lift) which included the appropriate use of both the EZ Stand and EZ sling lifts. NA-A was verified to have been in attendance at the in-service, NA-B was not in attendance. During a subsequent interview on 8/23/19, at 11:30 a.m. the DON verified her expectation that staff followed the individualized resident plan of care and followed the facility policies.

RN-A was interviewed on 8/23/19, at 11:30 a.m. and verified all residents using the EZ stand and EZ sling lift are being reviewed by therapies for safety and use of the appropriate device and the care plan is being updated appropriately.

Review of the facility policy Safe Patient Handling dated 6/16: Preferred Methods for Lifting and Transferring Clients: The key to your successful lift program is the correct assessment of the patients for the four point lift and the stand assist lift; clear and consistent communications regarding the need for assistive devices for individual patients; and the skillful use and familiarity of the lift by your associates. Based on the patient's classification from the Plan of Care, specific methods of transferring and lifting will be designated for each patient.

Review of the the facility policy: EZ Stand dated 4/06: Policy this mechanical aid will be used, as

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F 689	Continued From page 4 necessary, to assist in moving a resident. Purpose: To help reduce manual lifting of dependent or obese residents with safety and minimal effort. The EZ Stand was designed specifically for toileting and changing briefs of residents. (Used twice for chair to bed transfer) Residents should be able to bear some weight. (Care plan: Physically unable to bear own weight or walk). General Safety Requirements: When using the EZ Stand two people will be in attendance beside the resident. (Care Plan indicated 1-2 persons for EZ Stand use).	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 9, 2019

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: Project Number H5382015C

Dear Administrator:

On August 23, 2019, an abbreviated standard survey was conducted to investigate complaint #H5382015C 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.

The investigation resulted in no deficiencies being issued. Electronically attached is your copy of the Federal Form CMS-2567. 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. Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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 08/23/2019

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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: From August 22-23, 2019, an abbreviated survey was conducted to determine compliance with State licensure. No correction orders were issued. The following complaint was found to be substantiated:	2 000		

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2 000	Continued From page 1 H5382015C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		