

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 06/04/2025
NAME OF PROVIDER OR SUPPLIER Madison Healthcare Services		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Second Avenue Madison, MN 56256	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], 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.</p> <p>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.</p> <p>During a 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], 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.</p> <p>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 nutritional status.</p> <p>R1's care plan dated 3/26/25, indicated R1 would maintain adequate nutritional status.</p> <p>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 plaque 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).</p> <p>R1's signed physicians orders dated 5/21/25, lacked documentation R1 received any medication for xerostomia.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 6/4/25 at 2:08 p.m., 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.</p> <p>A facility policy notifying the provider was requested but facility stated they did not have a specific policy on notifying the provider.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], 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.</p> <p>R1's care plan dated 3/26/25, lacked documentation about R1's wound care.</p> <p>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.</p> <p>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.</p> <p>Review of R1's electronic health record (EHR) skin observation tool from 3/26/25 to 6/1/25, revealed the following:</p> <p>3/26/25, left thigh front surgical incision.</p> <p>4/16/25, incision to left hip, staples intact.</p> <p>4/23/25, left trochanter (hip), surgical incision 11 centimeters (cm) X 0.1 cm.</p> <p>5/1/25, continues with incision to left hip.</p> <p>5/7/25, continues to have incision on left hip.</p> <p>5/14/25, nothing about hip.</p> <p>5/21/25, surgical would to left hip healed at this time.</p> <p>6/1/25, no skin concerns noted.</p> <p>R1's Electronic Treatment Administration Record (ETAR) dated 4/1/25 to 6/5/25, identified R1 received dressing changes every three days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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 wound had been assessed since R1 came back from the hospital.</p> <p>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 wound. LPN-A removed gloves and stated she was going to chart the wound later.</p> <p>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.</p> <p>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.</p> <p>A call was placed to R1's medical provider, however no return call was received.</p> <p>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.</p> <p>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.</p>		