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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Healthcare Services	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self-administer medications (SAM) for 1 of 1 resident (R41) reviewed for medication administration.Findings include: R41s facesheet indicated R41 had Alzheimer's disease, heart failure, and hypertension.R41s care plan dated 12/10/25, lacked documentation that R41 could self-administer medications. R41's electronic medical record (EMAR) lacked a [NAME] assessment. During an observation on 1/26/26 at 11:30 a.m., licensed practical nurse (LPN-A), placed R41s Xarelto 20mg medication in a medication cup in front of R41 at the dining room table. R41 indicated she wanted to eat a couple bites before she took her medications. LPN-A left medication cup with resident and walked away. LPN-A passed medications to two other residents. At 11:40 a.m., LPN-A talked to R41, R41 stated she took her medication and LPN -A stated thanks and walked away. In an email from director of nursing (DON) on 1/26/26 at 2:27 p.m., DON indicated a self-administration assessment was not completed for R41. During an interview on 1/26/2026 at 4:05 p.m., LPN-A confirmed the medication was set in front of R41 and LPN-A did not observe R41 take the medication. LPN -A stated R41 likes to have a few bites of food before R41 takes the medication. LPN indicated she did not know if R41 had a self-administration assessment. During an interview on 1/26/2026 at 4:48 p.m., DON stated her expectations were for staff to watch all residents take their medications. DON further stated R41 was on the list to have a self-administration assessment completed but that it had not been completed yet.Facility policy titled medication self-administration revised 9/25, residents may self-administrate drugs if a registered nurse (RN) has determined that it is safe.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and document review, the facility failed to ensure the call light was accessible for 1 of 1 residents (R30) who was reviewed for call light placement.Findings include:R30's face sheet dated 1/27/26, indicated R30 had low back pain, osteoarthritis, and a wedge compression fracture of R30s lumbar. R30's care plan dated, 1/8/26, directed staff to make sure R30's call light was within reach and to encourage R30 to use the call light. During an observation on 1/26/2026 at 10:02 a.m., R30 was sitting in the recliner covered with a blanket. R30's call light was attached to the bed rail across the room and not within reach of R30.During an observation on 1/26/2026 at 3:58 p.m., R30 was sitting in the recliner covered with a blanket. R30s call light was still attached to the bed rail across the room. R30 indicated if she needed anything she would use the call light to call the nurse for assistance. R30 stated R30 was able to use the call light but the call light was not within reach. R30 further stated she could not call for help because the call light was attached to the bed and no within her reach. R30 indicated she was unable to get to the call light across the room. During an observation/interview on 1/26/2026 at 4:16 p.m., trained medication aid (TMA) confirmed R30s call light was attached to R30s bed and R30 could not reach the call light. TMA moved R30s call light to her recliner and R30 stated oh I can call for help now.During an interview on 1/26/2026 at 4:52 p.m., director of nursing (DON) stated she expected all residents to have their call light by them at all times. DON further stated R30 could use her call light appropriately and R30's care plan stated R30 was to have her call light by here at all times. DON indicated it was important residents have their call lights so they could call for assistance if they needed it.Facility policy titled call light - answering of revised 6/25 when resident is in bed or confined to a chair, call light will be within easy reach of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure resident status was accurately reflected in the Minimum Data Set (MDS) for 1 of 1 residents (R6) reviewed for pressure ulcers.Findings Include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual for Version 1.18.11 dated 10/23, was published by the Centers for Medicare & Medicaid Services (CMS). Section M of the RAI identified intent was to document the risk, presence, appearance, and change of pressure ulcers/injuries. The RAI identified if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period, to proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. The RAI identified a stage 3 pressure ulcer as full thickness tissue loss, in which subcutaneous fat may be visible and it may include undermining or tunneling. R6's admission Minimum Data Set (MDS) dated [DATE], identified R6 had moderate cognitive impairment and had diagnoses which included, hypertension, thyroid disorder and polyneuropathy (disease of nervous system). R6's MDS identified R6 had one stage 3 pressure ulcer. R6's care plan revised 11/6/25, identified R6 had potential for skin impairment due to impaired mobility, incontinence and Braden score of 18, indicating a mild risk for pressure injuries. Interventions included pressure-reducing devises: mattress on bed and cushion in wheelchair, and weekly treatment by wound care nurse. Review of R6's Wound Consult Nursing Note dated 11/6/25, identified wound located at the gluteal fold and was oblong. Wound cause appeared to be moisture associated skin damage (MASD) verses pressure. Wound 1.0 X 0.3 X 0.1 centimeter (cm). During observation on 1/26/26 at 9:46 a.m., nursing assistant (NA)-B and NA-C assisted R6 to stand up from toilet, using a sit to stand lift, performed perineal cares, then assisted R6 to recliner. R6 was noted to have a small black closed slit approximately 1/2 inch in length at the top of gluteal fold above coccyx. It appeared to have a white ointment covering the area. NA-B indicated the nurse had applied ointment to the area after R6 received morning cares. During interview on 1/26/26 at 12:48 p.m., NA-B indicated R6's wound appeared the same since R6's admission. During interview on 1/26/26 at 2:32 p.m., registered nurse/wound nurse (WN)-A stated had assessed R6's wound a few months ago. WN-A stated it was MASD. WN-A stated it was a small slit near R6's coccyx and it was not caused by pressure. WN-A confirmed R6 did not have a stage 3 pressure ulcer. During interview on 1/26/26 at 2:40 p.m., director of nursing (DON) confirmed that R6 did not have a stage 3 pressure ulcer and would expect the MDS to be accurately coded. DON indicated WN-A's wound assessment was completed during the MDS look back period so it should have been used for the MDS assessment. DON stated it was important for the MDS to be completed accurately to ensure it was properly documented and for financial reasons. DON indicated the facility would complete a correction of R6's admission assessment. The facility policy titled Assessments revised 12/25, identified purpose was to ensure all assessments were done according to federally mandated time frames. The policy identified all assessments were completed in Point Click Care (PCC) by the appropriate department, at minimum, within the mandated time frames, and dated within the MDS observation period, if applicable. The policy included various assessments to be completed on admission/readmission, quarterly, and with significant change.