STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING ______ B. WING ______	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION	**345 MANOR ROAD MARS HILL, NC 28754**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/12/24 through 11/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #75EI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/12/24 through 11/15/24. Event ID# 75EI11. The following intake was investigated NC00208084. Four (4) of the 4 complaint allegations did not result in deficiency.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 812	Address how the corrective action will be	11/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/03/2024

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 812	Continued From page 1 facility failed to remove expired food from 1 of 3 kitchen refrigerators (walk-in refrigerator). This practice had the potential to affect food served to residents. Findings Included An observation of the walk-in refrigerator in the kitchen on 11/12/24 at 9:40 AM with the Dietary Manager (DM) found one resealable plastic bag dated 11/3 that contained deli meat. The DM stated during the observation that opened and stored food should be kept for 7 days and then thrown out; she immediately removed the food. The DM stated the morning cook checks the walk-in refrigerator each morning for food out of date and discarded them. She stated the deli meat dated 11/3 was overlooked when the refrigerator was checked for expired food earlier in the day. The Administrator was interviewed on 11/15/24 at 2:09 PM. She stated the outdated deli meat would not have been served to the residents. The Administrator stated she was unsure if the deli meat had been misdated or overlooked and the facility's policy was to dispose opened food items after 7 days.	F 812	accomplished for those residents found to have been affected by the deficient practice: The facility failed to discard expired leftover food ready for use in 1 of 1 walk-in cooler. On 11/12/24 the Dietary Manager disposed of the expired turkey. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents have the potential be affected by the deficient practice. The Dietary Manager completed a 100% audit of food storage including refrigerators, freezers, and dry storage rooms to ensure all food was within usage dates, properly stored, labeled, and items were properly disposed of as identified. On 11/15/24 an ad hod QAPI was held to discuss the deficient practice and initiate a plan of correction with auditing tools. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/15/24 the Dietary Manager completed education with all current dietary staff on proper food procurement, storage, preparation and labeling. Any staff that did not receive the education will not be allowed to work until education has been completed. New facility dietary staff will complete education prior to working their first shift. The Dietary Manager will be responsible for ensuring education is received. Address what measures will be put into place or systemic changes made to	

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F 812	Continued From page 2	F 812	ensure that the deficient practice will recur: The Dietary Manager or designee will audit refrigerators, freezer, dry storage, and nourishment rooms to ensure all food was within usage dates, properly stored, and labeled 3 (three) times a week for 4 (four) weeks and weekly for eight (8) weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for 3 (three) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion date: 11/16/24	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345206	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 11/15/2024
NAME OF PROVIDER OR SUPPLIER **MADISON HEALTH AND REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **345 MANOR ROAD MARS HILL, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to accurately code a discharge Minimum Data Set and a quarterly Minimum Data Set (MDS) for 2 of 20 assessments reviewed for accuracy (Resident #79). Findings included: Resident #79 was admitted to the facility on 06/14/23. Resident #79's diagnoses included diabetes mellitus, hypoxic respiratory failure, and malnutrition. 1.a. A review of the wound care Nurse Practitioner (NP) progress note dated 09/03/24 revealed Resident #79 was being treated for an area on left buttock described as a non-blanchable dusky discoloration at the clinical stage of a deep tissue pressure injury (intact skin with localized area of persistent non-blanchable discoloration due to damage of underlying soft tissue). The discharge MDS assessment dated 09/03/24 revealed Resident #79's skin condition was completed on 09/09/24 by MDS Coordinator #1. The assessment inaccurately coded Resident #79 had no unhealed pressure ulcer/injury. During an interview on 11/14/24 at 2:57 PM MDS Coordinator #1 confirmed she completed the discharge MDS dated 09/03/24 for Resident #79. After review of the wound care NP progress note dated 09/03/24 MDS Coordinator #1 revealed the assessment was inaccurately coded to indicate there were no unhealed pressure ulcer and would be modified to reflect Resident #79 had a deep tissue pressure injury. b. A review of the wound care NP progress note dated 09/10/24 revealed Resident #79 was being treated for an area on left buttock described as dusky discoloration at the clinical stage of a deep tissue pressure injury. The quarterly MDS assessment dated 09/13/24 revealed Resident #79's skin condition was completed by MDS Coordinator #2. The assessment was inaccurately coded Resident #79 had one stage 3 pressure ulcer (full-thickness loss of skin with visible tissue). During an interview on 11/14/24 at 3:08 PM MDS Coordinator #2 confirmed she completed the quarterly MDS assessment dated 09/13/24. After review of the wound care NP progress note dated 09/10/24 MDS Coordinator #2 revealed the assessment was inaccurately coded to indicate there was one stage 3 pressure ulcer and would be modified to reflect Resident #79 had a deep tissue pressure injury. During an interview on 11/15/24 at 9:16 AM the Director of Nursing (DON) revealed the discharge

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345206	A. BUILDING: ______ B. WING ______	**11/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION	**345 MANOR ROAD MARS HILL, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1

(09/03/24) and quarterly (09/13/24) MDS assessments should be coded accurately to reflect the wound care NP progress notes that identified Resident #79 was being treated for a deep tissue pressure injury.

An interview was conducted on 11/15/24 at 2:11 PM with the Administrator. The Administrator revealed MDS assessments should be accurate and coded based on the wound care NP progress notes to show Resident #79 was treated for a deep tissue pressure injury.