PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

SEP 1 7 2014 continuation sheet Page of 25

CENTER	S FOR MEDICARE &	WEDICAID SERVICES	and an exercise and					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE F157 483.10 NOTIFY OF CHANGE HINDRY, DECLINE, ROA F157 483.10 NOTIFY OF CHANGE HINDRY, DECLINE, ROA CONSULT WITH RESIDENT'S PHYSICIAN AND IF KNOWN, RESIDENT'S LEGAL REPRESENTATIVE OR AN INTERESTED MEMBER WHEN THERE IS AN ACCIDENT INVOLVING THE RESIDENT WHICH RESULTS IN INJURY AND HAS THE POT FOR REQUIRING PHYSICIAN INTERVENTION; A SIGNIFICA CHANGE IN THE RESIDENT'S PHYSICAL, MENTAL OR PSYC SOCIAL STATUS (A DETERIOATION IN HEALTH, MENTAL OR PSYCHOSOCIAL STATUS IN EITHER LIFE THREATENING CONDITIONS OR CLINICAL COMPLICATIONS); A NEED TO ALTER TREATMENT SIGNIFICANTLY (A NEED TO DISCON: AN EXISTING FORM OF TREATMENT DUE TO ADVERSE CONSEQUENCES, OR TO COMMENCE A NEW FORM OF TO OR A DECISION TO TRANSFER OR DISCHARGE THE RESID FROM THE FACILITY AS SPECIFIED. THE FACILITY WILL ALSO PROMPTLY NOTIFY THE RESIDENT INTERESTED FAMILY MEMBER WHEN THERE IS A CHAN ROOM OR ROOMMATE ASSIGNMENT AS SPECIFICED IN A OR A CHANGE IN RESIDENT RIGHTS UNDER FEDERAL COSTATE LAW OR REGULATIONS AS SPECIFICED IN	С				
		345206	1-2-2-400-11-01-05-01-		08/14/2014			
NAME OF PE	ROVIDER OR SUPPLIER	N ·						
MADISON	HEALTH AND REHABIL	ITATION						
	Towns to the second				(¥5)			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD B				
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		NIL			
			F1	57 483.10 NOTIFY OF CHANGES(INJURY, DECLIN	E.ROOM. ETC.)			
F 157	483.10(b)(11) NOTIF	Y OF CHANGES	F 157	E FACILITY WILL IMMEDIATELY INFORM THE RE	SIDENT;			
SS=D	(INJURY/DECLINE/R			NICH T WITH RECIDENT'S BUYCICIAN AND IS KNOWN	NAME NOTICE			
				NSOLI WITH RESIDENT'S PHYSICIAN AND IF KNO	JWN, NOTIFY			
		liately inform the resident; ent's physician; and if	RES	DENT'S LEGAL REPRESENTATIVE OR AN INTERE	STED FAMILY			
		ident's legal representative	ME	MRED WHEN THERE IS AN ACCIDENT INVOLVING	THE 0/11/14			
	or an interested family member when there is an		IVIC		5 THE 9/11/14			
	accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's			SIDENT WHICH RESULTS IN INJURY AND HAS TH	POTENTIAL			
				FOR REQUIRING PHYSICIAN INTERVENTION: A SIGNIFICANT				
	physical, mental, or psychosocial status (i.e., a							
deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment		CHANGE IN THE RESIDENT'S PHYSICAL, MENTAL OR PSYCHO-						
		so	 CIAL STATUS (A DETERIOATION IN HEALTH, MEI	NTAL OR				
	significantly (i.e., a ne	eed to discontinue an						
	existing form of treatr		PSYCHOSOCIAL STATUS IN EITHER LIFE THREATENING					
		commence a new form of sion to transfer or discharge	CONDITIONS OR CLINICAL COMPLICATIONS): A NEED TO					
	the resident from the	facility as specified in						
	§483.12(a).		AL	TER TREATMENT SIGNIFICANTLY (A NEED TO DIS	CONTINUE			
	The facility must also	promptly notify the resident	A	EXISTING FORM OF TREATMENT DUE TO ADVE	RSE			
	and, if known, the res	sident's legal representative		NICEOUTNICES OF TO COMMENCE A NEW FORM	A OF TOPATAGE			
		nember when there is a		DISEQUENCES, OR TO COMMENCE A NEW FORM	OF TREATIME			
		ommate assignment as (e)(2); or a change in	OF	A DECISION TO TRANSFER OR DISCHARGE THE	RESIDENT			
	resident rights under	Federal or State law or		DOM THE EACH ITY AS SPECIEED				
		ied in paragraph (b)(1) of	1	THE PACIEIT AS SPECIFIED.				
	this section.		T	FACIITY WILL ALSO PROMPTLY NOTIFY THE RE	SIDENT AND,			
	The facility must reco	ord and periodically update	16	 	IVE OR			
		ne number of the resident's	,,,	THE RESIDENT S CONCRET RESERVAT				
	legal representative	or interested family member.	11	NTERESTED FAMILY MEMBER WHEN THERE IS A	CHANGE IN			
			R	 OOM OR ROOMMATE ASSIGNMENT AS SPECIFIE	D IN 483.15			
	Communication of the communica	T is not met as evidenced						
	by:	and staff interviews and		DR A CHANGE IN RESIDENT RIGHTS UNDER FEDE	RAL OR			
		cility failed to notify the	9	TATE LAW OR REGULATIONS AS SPECIFICED IN				
	legally responsible p							
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E P	ARAGRAPH B1 OF THIS SECTION	(X6) DATE			

Any deficiency statement ending within asterisk (*) denotes a deliciency 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 of days large. bllowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discretionally days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continue the days following the date these documents are made available to the facility. program participation.

Original Signature Date: Sept. 5, 2014 Facility ID: 923319

OFILITION	O I OIL MEDIONICE	MEDICAID SERVICES				ONID NO. 0936-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345206	B. WNG			08/14/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADISON	I HEALTH AND REHABIL	ITATION		3	45 MANOR ROAD		
MADIOON	THEALTH AND KEHADIL	HAHOR		MARS HILL, NC 28754			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) THE FACILITY WILL RECORD AND PERIODICALLY	ATE DATE	
E 4 E 7					THE ADDRESS AND BURNE WILLIAMS		
F 157			F	157	THE ADDRESS AND PHONE NUMBER OF THE RE	SIDENT'S	
	condition for 1 of 4 res	sidents (Resident #162).			LEGAL REPRESENTATIVE OR INTERESTED FAMIL	Y MEMBER.	
	The findings included:				THE NURSING 24 HOUR REPORT FORM WILL BE	REVISED	
Resident #162 was admitted to the 11/19/13 with diagnoses which indisease, vascular dementia with be disturbance, and chronic pain. Reference in the second control of the secon					TO INCLUDE A SECTION WHERE NURSES ON ALI	LSHIFTS	
		nentia with behavioral			WILL BE REQUIRED TO IDENTIFY CHANGES IN C	ONDITION	
	most recent quarterly Minimum Data Set (MDS) dated 01/15/14 assessed him as being cognitively intact. Review of Resident #162's medical record revealed a family member was listed as Resident				AND NOTIFICATION OF SAID EVENT TO A RESID	ENT'S LEGAL	
					REPRESENTATIVES OR INTERESTED FAMILY MEN	MBER. THE	
	#162's first emergenc	y contact, and Resident isted as Resident #162's			DIRECTOR OF NURSING WILL MONITOR THE 24	HOUR	
	second emergency co				REPORT DAILY FOR 60 DAYS TO ENSURE NOTIFI	CATIONS	
	Review of Resident # identified problem with	162's care plan revealed an			HAVE BEEN MADE. THESE MONITORING RESUL	TS WILL BE	
	verbally aggressive be	ehavior. Resident #162's ed a behavior plan that			INCLUDED IN THE QUALITY ASSURANCE MONTH	ILY MEETING.	
	gave instructions rega	rding ways to respond to			THE D.O.N. WILL SCHEDULE A MANDATORY INS	ERVICE FOR	
	ways to prevent his or	verbal aggressiveness and atbursts. In the approaches			ALL NURSES TO REVIEW THE REVISED PROCEDU	JRE FOR	
	the facility would trans	162's care plan, it was listed afer Resident #162 to the			NOTIFICATION OF LEGAL REPRESENTATIVES AND	INTERESTED	
	medical record if he b	e hospital specified in the ecame out of control with			FAMILY MEMBERS AND WILL INCLUDE SAID PRO	DCEDURE	
	his verbal and physica	al aggression.		1	N NURSE JOB SPECIFIC ORIENTATION PROGRAM	1. THE OFFICE	
	medical record reveal			ı	MANAGER WILL UPDATE ADDRESSES AND PHON	E NUMBERS	
	multiple occasions wh and verbally aggressive	en Resident #162 was rude ve toward others.			OF CURRENT RESIDENT LEGAL REPRESENTATIVE	ES	
	Review of nursina not	es from Resident #162's			OR INTERESTED FAMILY MEMBERS AND WILL CO	ONTINUE	
		date of 01/13/14 revealed			TO UPDATE SUCH INFORMATION ON A SCHEDU	JLE THAT	
		a new roommate, and his ed during the evening from			COORESPONDS TO THE RESIDENT CARE PLAN S	CHEDULE.	

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	COMPLETED
		345206	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER HEALTH AND REHABI	LITATION		STREET ADDRESS, CITY, STATE, ZIP COD 345 MANOR ROAD MARS HILL, NC 28754	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION DATE
F 157	harm toward the room from 01/13/14 at 9:2 called the Administrate been made to send room at the hospital record. Interview with Nurse revealed when a resemengency or change sent out to the hospital and family are to be #1 stated she did not #162's family or guate been made to call effor transportation to #1 stated there was had called to notify family. Nurse #1 st stressful situation. #162's face sheet, I contacted someone #162's family memblisted as the first co sheet, and not the gas contact #2.	d aggression to verbal abuse te and then threats of physical ormate. The nursing note 20 PM revealed Nurse #1 had ator and the decision had the resident to the emergency specified in the medical #1 on 08/13/14 at 8:05 AM sident in the facility has an ge in condition, or is being oital, the resident's physician enotified immediately. Nurse on termember calling Resident ardian once the decision had emergency medical services of the emergency room. Nurse on documentation that she Resident #162's guardian or ated it had been a very When looking at Resident Nurse #1 stated if she had a it would have been Resident there because that was who was notact person on his face guardian, who had been listed	F	THE FACILITY QUALITY ASSURANT BE REVISED TO INCLUDE MONI -EVERY WEEK FOR 4 WEEKS AND CONDITION NOTIFICATIONS AN OF NURSING MONITORING OF S AS WELL AS THE ONGOING UPD. DENT LEGAL REPRESENTATIVE OF FAMILY MEMBER INFORMATION THE CARE PLAN SCHEDULE. THE CORRECTIVE ACTIONS OF RE NURSING REPORT FORM, INSER ON THE DESCRIBED CHANGE IN R MONITORING OF SAID NOTIFICATION DIRECTOR OF NURSING AND AN UPDATE OF CURRENT RESIDENT INTERSOLVE THE DEFICIENT PRACTION RESOLVE THE DEFICIENT PRACTICE.	TORING - D THEN MONTHLY- D OF THE DIRECTOR SAID NOTIFICATIONS ATES OF THE RESI- PRINTERESTED N ACCORDING TO EVISING THE 24 HOUR VICING THE NURSES PROCEDURE, TIONS BY THE IMMEDIATE LEGAL REPRESENTA- EMBERS WILL CE FOR THE RESIDENT
	08/13/14 at 3:57 PM admissions, she as with completing the contact information staff when notifying	dmissions Director (AD) on which revealed during all sisted residents and families first, second, and third sheet, which was used by all family members about		FOUND TO BE AFFECTED AND THE THE POTENTIAL TO BE AFFECTED. THE SYSTEMIC CHANGE OF REVIS	ING THE 24 HOUR
	care plan meetings resident with a lega	n and when inviting families to . The AD stated whenever a al guardian was admitted, the		AND MONITORING OF SIGNIFICAN	
	guardianship paper	rs were reviewed, copled for	1	RESIDENT'S PHYSICAL MENTAL O	B BEACHOSOCIAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CLIVIED	S FOR WEDICARE &	WEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 12		CONSTRUCTION		PLETED
		345206	B. WNG				C
NAME OF P	ROVIDER OR SUPPLIER					08/	14/2014
IVANIL OF F	NOVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADISON	HEALTH AND REHABIL	ITATION		3	45 MANOR ROAD		
ECONTROL WALLEST CONTROL OF THE SECOND				N	ARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X6) COMPLETION DATE
		* ***			STATUS, A NEED TO ALTER TREATMENT SIGNI	FICANTLY	!
F 157	Continued From page the chart, and the leg	e 3 al guardian was listed as the	F	157	OR A DECISION TO TRANSFER OR DISCHARGE I	ROM	
	resident's first contact in the medical record so that they could be contacted first whenever there				THE FACIITY, THE ONGOING MONITORING OF S	AID	
	was an emergency or	a change in condition.			FORM BY THE DIRECTOR OF NURSING EACH W	EEK	
		al guardian of Resident #162 M revealed he had not been			AND THE PROCEDURE CHANGE OF UPDATING)	1
	contacted by any staf	f at the facility regarding any 162's condition or behaviors			THE ADDRESS AND PHONE NUMBER OF EACH		
	during the months of				LEGAL REPRESENTATIVE OR INTERESTED FAM	LY	! !
	stated he had not bee	en informed of any threat of			MEMBER ACCORDING TO THE CARE PLAN SCH	EDULE	
	resident at the facility	nad made toward any other . The guardian of Resident			AND INCLUDING THE MONITORING OF THIS		
J		ntire stay at the facility and			PROCEDURE IN THE MONTHLY FACILITY QUAL	ITY	
	had provided the facil documentation of gua	ity with the legal rdianship at the resident's			ASSURANCE PROGRAM HAS CREATED THE MEA	ASURE	
5		ty. The guardian stated 162's stay at the facility, the			WHICH WILL ENSURE THE DEFICIENT PRACTIC	E DOES NO	г
# B		ad been changed from initial other changes had been			RECUR. THE INCLUSION OF THE REVISED PROC	EDURE FO	R
		dian of Resident #162 been invited to a care plan			DOCUMENTATION OF SIGNIFICANT CHANGES (ON THE 24	
	meeting, had never p				HOUR NURSING REPORT FORM BEING INCLUD	ED IN THE	
	of the facility's care pl				NURSE JOB SPECIFIC ORIENTATION PROGRAM,		
	emergency room if he	e exhibited verbal and			MONITORING OF THE REVISED 24 HOUR NURS	NG REPOR	Т
	physical aggression.	A 17 171 5 182 500			BY THE DIRECTOR OF NURSING AND THE REVIS		
	AM revealed facility h	Manager on 08/14/14 at 8:05 ad been given guardianship			MONTHLY QUALITY ASSURANCE PROGRAM TO		
	asked why Resident	nt #162's admission. When #162's guardian was not		į	MONITORING OF UPDATING OF RESIDENT INF		
000000000000000000000000000000000000000	listed as Resident #16	32's first emergency contact the office manager stated	50 \$0 \$0		BASED ON THE CARE PLAN SCHEDULE WILL CRI		
- 110	she had thought the g	uardianship had been mergency contact had been	f		INTERNAL MONITORING TOOLS TO MAKE SURE	THE	
1	, i o ronou unu so me el	norganity contact riad been		i	SOLUTIONS TO THE DESICIENT SPACTICES ARE	CHICTAINIE	. 1

SOLUTIONS TO THE DEFICIENT PRACTICES ARE SUSTAINED.

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 50		(X3) DATE SURVEY COMPLETED
	345206	B. WNG		C 08/14/2014
	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD	00/14/2014
HEALTH AND REHABIL	TIATION		MARS HILL, NC 28754	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION
changed. The office radditional legal paper in guardianship after fa 483.15(h)(2) HOUSER MAINTENANCE SER. The facility must provimaintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation facility failed to label to devices with resident bathrooms. The findings included: During an observation the resident bathroom 112 there was a bedp toilet. There was no rebedpan.	manager stated she had no work regarding any change Resident #162's admission. KEEPING & VICES de housekeeping and necessary to maintain a comfortable interior. is not met as evidenced as and staff interviews the nedpans and urine collection names for 5 resident on 08/12/14 at 11:07 AM in between rooms 110 and an sitting on the back of the esident name visible on the		THE FACILITY WILL PROVIDE HOUSEKEEPING AN MAINTENANCE SERVICES NECESSARY TO MAIN SANITARY, ORDERLY AND COMFORTABLE INTE THE MEDICAL SUPPLY COORDINATOR HAS CRE A CURRENT LIST OF ALL RESIDENTS REQUIRING OR URINAL. THE ADMISSION CARE PLAN HAS REVISED TO INCLUDE QUESTIONS ON URINAL NEEDS AND THE MEDICAL SUPPLY COORDINATION OF THE MEDICAL SUPPLY COORDINATION OF THE MED SUPPL	TAIN A RIOR. ATED S A BEDPAN BEEN AND BEDPAN ATOR OR IN RUCTED TO LIST. THE RDINATOR NANCE OF
120 there was a urina	I sitting on the shelf above		LABELING OF NAME AND DATE OF ISSUANCE	
D	00/40/4 44 47 444		THE PROCEDURES FOR PROVIDING URINALS	AND
During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf above the toilet. There was no resident name visible on the collection hat.			BEDPANS WILL BE REVISED TO REQUIRE THA	THE
	ROVIDER OR SUPPLIER HEALTH AND REHABILI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page changed. The office r additional legal paper in guardianship after f 483.15(h)(2) HOUSER MAINTENANCE SER The facility must provi maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation facility failed to label b devices with resident bathrooms. The findings included: During an observation the resident bathroom 112 there was a bedp- toilet. There was no r bedpan. During an observation the resident bathroom 120 there was a urine athe toilet. There was the urinal. During an observation the resident bathroom 120 there was a urine above the toilet. There above the toilet. There	This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label bedpans and urine collection devices with resident names for 5 resident bathrooms. The findings included: During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was a urine solded. During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf above the toilet. There was no resident name collection hat on the shelf above the toilet. There was no resident name collection hat on the shelf above the toilet. There was no resident name visible on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was a urine collection hat on the shelf above the toilet. There was no resident name visible on the urinal.	PEDEFICIENCIES CORRECTION X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP A. BUILDING	A BUILDING 345208 ROWDER OR SUPPLIER HEALTH AND REHABILITATION REGULATORY OR ISC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFTICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 4 changed. The office manager stated she had no additional legal paperwork regarding any change in guardianship after Resident #162's admission. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label bedpans and urine collection devices with resident names for 5 resident bathrooms. The findings included: During an observation on 08/12/14 at 11:07 AM in the resident bathroom between rooms 110 and 120 there was a urinal sitting on the back of the toilet. There was no resident name visible on the bedpan. During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was an oresident name visible on the bedpans. During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was an oresident name visible on the bedpans on the collection had to on the shelf above the toilet. There was no resident name visible on the bedpans and urine collection had 120 there was a urinal sitting on the back of the toilet. There was no resident name visible on the bedpans. During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was a no resident name visible on the bedpans and urine collection had not on the shelf above the toilet. There was no resident name visible on the bedpans and urine collection had not on the shelf above the toilet. There was no resident name visible on the bedpans and urine collection had not on the shelf above the toilet. There was no resident name visible on the shelf above the toilet. T

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Interpretation and the second	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245206	B. WNG		С
NAME OF PROVIDER OR SUPPLIER	345206	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	08/14/2014
MADISON HEALTH AND REHABILITATI	ION		345 MANOR ROAD MARS HILL, NC 28754	
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
F 253 Continued From page 5 During an observation on the resident bathroom betw 216 there was a bedpan of toilet. There was no reside urinal. During an observation on the resident bathroom betw 124 there was a urinal on the resident bathroom betw 112 there was a bedpan sitoilet. There was no reside bedpan. During an observation on the resident bathroom betw 112 there was a bedpan sitoilet. There was no reside bedpan. During an observation on the resident bathroom betw 120 there was a urinal on the resident bathroom betw 215 there was a urine collete behind the toilet. There was visible on the collection has the collection has a bedpan or toilet. There was a bedpan or toilet. There was no reside bedpan. During an observation on the resident bathroom betw 216 there was a bedpan or toilet. There was no reside bedpan. During an observation on the resident bathroom betw 216 there was a bedpan or toilet. There was no reside bedpan.	ween rooms 214 and on the shelf behind the ent name visible on the 108/12/14 at 11:22 AM in ween rooms 222 and the shelf behind the ent name visible on the 108/12/14 at 4:55 PM in ween rooms 110 and itting on the back of the ent name visible on the 108/12/14 at 4:57 PM in ween rooms 118 and the shelf behind the ent name visible on the 108/12/14 at 4:58 PM in ween rooms 213 and ection hat on the shelf as no resident name tt. 108/12/14 at 5:00 PM in ween rooms 214 and on the shelf behind the ent name visible on the 108/12/14 at 5:01 PM in ween rooms 214 and on the shelf behind the ent name visible on the 108/12/14 at 5:01 PM in ween rooms 222 and 108/12/14 at 5:01 PM in ween rooms 222 and 108/12/14 at 5:01 PM in ween rooms 222 and 108/12/14 at 5:01 PM in ween rooms 222 and	F 2	MEDICAL SUPPLY COORDINATOR OR I SPONSIBLE FOR PROVIDING RESIDENT URINALS AND BEDPANS. THE D.O.N. W INSERVICE FOR NURSING AND HOUSE TO INSTRUCT ON THE NEED FOR URIN, TO BE LABELED WITH RESIDENT NAME, THIS INSERVICE WILL BE INCLUDED IN T NURSES, C.N.A. AND HOUSEKEEPER JO. ORIENTATION PROGRAM. RESIDENT BA' BE CHECKED FOR LABELS/NAMES ON UR WEEKLY BY THE MEDICAL SUPPLY COOR DESIGNEE AND 4 TIMES WEEK BY Q.A.C. THE MONTHLY Q.A PROGRAM WILL BE R INCLUDE A 5 DAY PER WEEK BATHROOM OF BEDPANS AND URINALS FOR 30 DAYS MONITORING THEREAFTER. THE CORRECTIVE ACTIONS OF CREATING LIST OF ALL RESIDENTS WHO NEED BEDR URINALS ,HAVING THE MEDICAL SUPPLY /DESIGNEE BE RESPONSIBLE FOR PROVID	S WITH LABELED VILL HOLD AN GEEPING STAFF ALS/BEDPANS DATE ISSUED HE 3 SPECIFIC THROOMS WILL INAL/BEDPANS DINATOR OR DORDINATOR. EVISED TO 1 MONITORING 5 AND WEEKLY A FACILITY ANS AND COORDINATOR

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OLIVILIV	O I ON MEDICARE &	VIEDICAID SERVICES	- ugu	· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1558 FES	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Č		345206	B. WING _		C 08/14/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2014	
la cons				345 MANOR ROAD		
MADISON	HEALTH AND REHABIL	TATION				
				MARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETION	
F 253	Continued From page	6	F 0	50		
. 200			F 2	53		
	urinal.	esident name visible on the				
	During an observation on 08/13/14 at 8:08 AM in the resident bathroom between rooms 110 and 112 there was a bedpan sitting on the back of the			INCLUDE BEDPAN AND URINAL NEEDS AI	ND CHECKING OF	
				RESIDENT BATHROOMS FOR CORRECTLY	LABELED UNITS	
	toilet. There was no rebedpan.	esident name visible on the		WILL RESOLVE THE DEFICIENT PRACTICE	FOR THE RESIDENTS	
	During an observation on 08/13/14 at 4:57 PM in the resident bathroom between rooms 118 and 120 there was a urinal on the shelf above the			AFFECTED AND THOSE HAVING POTENTIA	AL TO BE AFFECTED.	
				THE SYSTEMIC CHANGE OF REVISING THE	JOB DESCRIPTIONS	
		esident name visible on the		OF THE MEDICAL SUPPLY AND Q.A. COOR	DINATORS TO HAVE	
				RESPONSIBILITY FOR PROVIDING, LABELII	NG AND MONITOR-	
	the resident bathroom	on 08/13/14 at 8:10 AM in between rooms 213 and collection hat on the shelf		ING BEDPANS/URINALS AND THE MONITO	ORING OF RESIDENT	
		re was no resident name		BATHROOMS WILL CREATE THE MEASUR	ES TO ENSURE THE	
				DEFICIENT PRACTICE DOES NOT OCCUR.T	HE STAFF INSER-	
	the resident bathroom	on 08/13/14 at 8:12 AM in between rooms 214 and		VICING, REVISION OF THE MONTHLY FAC	ILITY Q.A. PRO-	
	toilet. There was no re	an on the shelf behind the esident name visible on the		GRAM TO INCLUDE MONITORING THE S	YSTEM WHEREBY	
	bedpan.			THE MEDICAL SUPPLY COORDINATOR ISS	UES LABELED	
	the resident bathroom	on 08/13/14 at 8:13 AM in between rooms 222 and		BEDPANS/URINALS AND ACTUAL BATH	ROOM MONITOR-	
	224 there was a urinal on the shelf behind the toilet. There was no resident name visible on the urinal.			ING WILL DEVELOP THE INTERNAL PLAN THE SOLUTIONS ARE SUSTAINED.	TO ENSURE	
	the resident bathroom 112 there was a bedpa	on 08/13/14 at 3:28 PM in between rooms 110 and in sitting on the back of the esident name visible on the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(a) (b)	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345206	B. WNG		С
	ROVIDER OR SUPPLIER HEALTH AND REHAB		S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 45 MANOR ROAD IARS HILL, NC 28754	08/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 253	the resident bathroo 120 there was a urin toilet. There was no urinal During an observation the resident bathroo 215 there was a urin above the toilet. The visible on the collect During an observation the resident bathroo 216 there was a bed toilet. There was no bedpan. During an observation the resident bathroo 224 there was a urin toilet. There was no urinal. During an interview of Nurse Aide (NA) #1 equipment for reside and urine collection of	on on 08/13/14 at 3:30 PM in m between rooms 118 and hal on the shelf behind the president name visible on the on on 08/13/14 at 3:31 PM in m between rooms 213 and he collection hat on the shelf here was no resident name higher on 08/13/14 at 3:32 PM in m between rooms 214 and he resident name visible on the on on 08/13/14 at 3:33 PM in m between rooms 222 and hal on the shelf above the resident name visible on the on 08/13/14 at 3:48 PM with stated all personal care into which included bedpans devices that were stored in	F 253		
	marked with the resiplastic bag around the stating the urinal in the stating and stating an interview of NA #2 stated all personal residents which included collection devices the	were supposed to be clearly dent's name and have a nem. NA #1 continued by the bathroom between rooms have been visibly labeled. on 08/13/14 at 4:08 PM with sonal care equipment for ided bedpans and urine at were stored in resident posed to be clearly marked			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
				s		С
NAME OF B	ROVIDER OR SUPPLIER	345206	B. WING _	OTERST APPEARS OF A STATE WE SOME		08/14/2014
	HEALTH AND REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253	During an observation the resident bathroom 215 there was a urine above the toilet. There visible on the collection the resident bathroom 215 there was a urine above the toilet. There visible on the collection the resident bathroom 216 there was a bedpe toilet. There was no resident bathroom 216 there was a bedpe toilet. There was no resident bathroom 224 there was a urine atoilet. There was no resident bathroom 224 there was a urine atoilet. There was no resident bathroom was not urinal. During an interview or Nurse Aide (NA) #1 stequipment for resident and urine collection deresident bathrooms was marked with the resident plastic bag around the stating the urinal in the 118 and 120 should have buring an interview or NA #2 stated all persone residents which include collection devices that	n on 08/13/14 at 3:30 PM in between rooms 118 and I on the shelf behind the esident name visible on the n on 08/13/14 at 3:31 PM in between rooms 213 and collection hat on the shelf e was no resident name in hat. I on 08/13/14 at 3:32 PM in between rooms 214 and an on the shelf behind the esident name visible on the on 08/13/14 at 3:33 PM in between rooms 222 and I on the shelf above the esident name visible on the	F 25	53		

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(2)		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
Î		345206	B. WING _				14/2014
The second secon	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		34	REET ADDRESS, CITY, STATE, ZIP CODE 15 MANOR ROAD ARS HILL, NC 28754	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	
F 253	with the resident's nathe urine collection has rooms 213 and 215 stabeled. During an interview of NA #3 stated all personal pers	me. NA #2 further stated at in the bathroom between hould have been visibly n 08/13/14 at 4:19 PM with onal care equipment for ded bedpans and urine t were stored in resident exisibly labeled. NA #3 he bedpan in the bathroom and 112 should have been no 08/13/14 at 4:37 PM with onal care equipment for ded bedpans and urine ould be visibly labeled. NA unlabeled urinal between nd the unlabeled bedpan and 216 should be visibly	F2	2253			
F 280 SS=D	the Director of Nursin expectation that bedp and labeled with the r further stated she had these personal care it 483.20(d)(3), 483.10(PARTICIPATE PLAN! The resident has the incompetent or otherwincapacitated under the	right, unless adjudged vise found to be ne laws of the State, to g care and treatment or	F 2	280	F280 483.20 RIGHT TO PARTICIPATE PLANNI REVISE CP THE RESIDENT HAS THE RIGHT, UNLESS ADJ INCOMPETENT OR OTHERWISE FOUND TO OTHERWISE FOUND TO BE INCAPACITATED	09/11/14 UDGED BE	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W 102000000		E CONSTRUCTION	(X3) DATE	SURVEY
92		245000	B. WING		, and the second		С
NAME OF D	ROVIDER OR SUPPLIER	345206	B. WING		TOTAL ADDRESS CITY STATE THE CORE	08/	14/2014
	HEALTH AND REHABIL	TATION		3	TREET ADDRESS, CITY, STATE, ZIP CODE 45 MANOR ROAD MARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280 Continued From page 9			F	280	THE LAWS OF THE STATE, TO PARTICIPATE	IN	
	A comprehensive care plan must be of within 7 days after the completion of				PLANNING CARE AND TREATMENT OR CHA	NGES IN	
	interdisciplinary team,	sment; prepared by an that includes the attending			IN CARE AND TREATMENT.		
		d nurse with responsibility other appropriate staff in			THE FACILITY WILL DEVELOP A COMPREHE	NSIVE CAR	E
		ned by the resident's needs, cticable, the participation of			PLAN WITHIN 7 DAYS AFTER THE COMPLE	TION OF TH	HE
		ent's family or the resident's			COMPREHENSIVE ASSESSMENT, PREPARE	D BY AN	
					INTERDISCIPLINARY TEAM, THAT INCLUD	S THE	
	odon dooddoment.				ATTENDING PHYSICIAN, A REGISTERED NU	IRSE WITH	
					RESPONSIBILITY FOR THE RESIDENT, AND	OTHER	
		is not met as evidenced			APPROPRIATE STAFF IN DISCIPLINES AS DI	TERMINEC)
		ews, and family and staff			BY THE RESIDENT'S NEEDS AND, TO THE E	XTENT	
	responsible parties to				PRACTICABLE, THE PARTICIPATION OF TH	E	
	(Residents #49, #6, and	plans for 3 or 4 residents and #162).			RESIDENT, THE RESIDENT'S FAMILY OR TH	E RESIDEN	T'S
	The findings included:				LEGAL REPRESENTATIVE, AND PERIODICA	LLY	
		admitted to the facility on			REVIEWED AND REVISED BY A TEAM OF O	UALIFIED	
		es which included chronic and Alzheimer's Disease.			PERSONS AFTER EACH ASSESSMENT.		
Resident #49's most recent quarterly Mir Data Set (MDS) dated 07/02/14 assesse					THE OFFICE MANAGER WILL PRINT OFF CO	MPUTER-	
		npaired. Resident #49's s responsible person in his			IZED FACE SHEETS WITH RESPONSIBLE PAR	RTIES LISTE	D
	medical record.	•			AND CARE PLAN NOTICE RESPONSIBILITIES	NOTED O	N
	Review of facility Inter Attendance Sign-in for				EACH RESIDENT IN THE FACILITY TO ENSUI	RE THAT	
	revealed date of meet 01/17/14, and 04/21/1	ings were 10/29/13,			ALL RESPONSIBLE PARTY INFORMATION IS	COMPLET	E

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 5		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	10				-	(
	10	345206	B. WNG_			08/	14/2014	
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		34	TREET ADDRESS, CITY, STATE, ZIP CODE 45 MANOR ROAD IARS HILL, NC 28754		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	OULD BE COMPLETION		
F 280	member was listed as family member signat care plan attendance. An interview with the 08/13/14 at 11:15 AM been invited to a care participate in the deverage plan in any way Resident #49 had resulted in the deverage plan in any way Resident #49 had resulted in the switch with facility 08/13/14 at 4:39 PM in handled all responsible participate in the SW stated the resulted in the switch was generated who also listed on the face sheet in the sign in sheet. The SW Coordinator was not inviting the resident's the contact person's in meeting sign in sheet. Interview with facility 10:23 AM revealed sheet in the sident's first contact person's in meetings. When receptionist stated sheet resident's first contact medical record. The	sinvited on the form, no cures were on any of the sign in sheets. family of Resident #49 on revealed the family had not a plan meeting or to elopment of Resident #49's during the nine months ided in the facility. social worker (SW) on revealed the receptionist illities of inviting residents es to care plan meetings. ceptionist mailed out to the address listed in the es sheet from the medical about the family member e care plan meeting sign in the care plan meeting sign ed by the MDS Coordinator, erson named as first contact the medical record on the W stated the MDS involved with the process of contact person, but listed name on the care plan is of evere scheduled for care in given the list, the e mailed a postcard to the trom the face sheet in their receptionist stated she tried	F	280	THOSE IN THE FAMILY WHO WISH TO INTERDISCIPLINARY CARE PLAN MEEE JOB DESCRIPTION OF THE OFFICE MA WILL BE REVISED TO INCLUDE THE RE OF UPDATING RESPONSIBLE PARTY II AND CARE PLAN NOTICE RESPONSIBIL COMPUTERIZED FACE SHEET AS CHA BECOME KNOWN. THE INTERDISCIPLINARY CARE PLAN WILL BE REVISED TO REQUIRE THAT V AFTER COMPLETION OF THE COMPRI ASSESSMENT, THE FACILITY SOCIAL V CONTACT THE RESIDENT, RESIDENT'S RESIDENT'S LEGAL REPRESENTATIVE E AND FOLLOWUP TELEPHONE CALL V DOCUMENTED IN SOCIAL SERVICE N TO A INTERDISCIPLINARY CARE PLAN ASSIST IN DEVELOPMENT OF THE COM	ETINGS. THE NAGER SPONSIBIL NFORMAT ITY IN THE NGES PROCEDU WITHIN 7 C EHENSIVE WORKER V S FAMILY C BY LETTER WITH RESU OTES , I MEETING MPREHEN:	E ITY ON RE AYS /ILL DR JLTS TO SIVE N	
		she sent out the post ist stated there was no			MEETINGS ACCORDING TO THE COMP	PREHENSIV	Έ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				2. 7.3.40		С	
		345206	B. WNG			08/14/2014	
	ROVIDER OR SUPPLIER 1 HEALTH AND REHABIL	TATION	STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA ASSURANCE PROGRAM WEY BE REVISED	ATE DATE	
F 280			F	280	MONTHLY MONITORING OF CARE PLAN S	SCHEDULE,	
	the cards and no follo	nentation kept regarding family response to ards and no follow up was done to ensure mily members had received the post card. eceptionist provided one of the cards that			WITH CHECKS OF DATES LETTERS WERE	SENT,	
	The receptionist provi				DATES CALLS WERE MADE, DATES OF AC	TUAL	
		members/contacts. The ne address of the facility			MEETINGS AND CHECKS OF ATTENDANTS	S AT CARE	
	resident's contact/fam	name and address of the ily. The back of the card			PLAN MEETINGS. A CHECK WILL ALSO BE	MAD E	
	reviewed and to pleas	bers care plan had been e call the Receptionist to			TO ENSURE FACE SHEET RESPONSIBLE PA	RTY/	
	5	time or the care plan could y. The bottom of the card			INTERESTED FAMILY UPDATES WERE CO	MPLETED	
	had the name of the fa numbers to contact th				WITH THE CARE PLAN SCHEDULE.		
					THE CORRECTIVE ACTIONS OF REVIEWIN	IG ALL	
	receptionist provided	nterview on 08/14/14 the a list of residents, which Resident #49, for whom she			CURRENT RESIDENT FACE SHEETS FOR U	PDATED	
	had sent cards out on	05/02/14. The receptionist			RESPONSIBILITY PARTY/FAMILY INFORM	NATION	
	#49 received the card				AND CORRECT COMPUTERIZED SECTION	I WHICH	
		ty Interdisciplinary Care			DESIGNATES THOSE TO CONTACT FOR C	ARE PLAN	
	which stated the date	in form for Resident #49, of meeting was 04/21/14,			MEETINGS, REVISING THE JOB DESCRIPT	ION OF THE	
	05/02/14 and not befo				SOCIAL WORKER TO BE RESPONSIBLE FO	PR NOTIFI-	
		s out for once their care			CATION OF RESIDENTS AND RESPONSIB	LE PARTIES	
	have the plan reviewe	pleted to invite them to d with them or have it			/ INTERESTED FAMILY MEMBERS AND D	OCUMENTA-	
	mailed to them.				TION OF NOTIFICATION RESULTS AS WEI	LL AS THE	
Interview with the MDS Coordinator on 08 at 2:58 PM revealed she generated the		he generated the	SCHEDULING THE CARE PLAN MEE			S BASED ON	
		lan attendance sheet for er a care plan revision was			THE COMPREHENSIVE ASSESSMENT SCH	HEDULE	
	needed: quarterly, wh	en there was a significant ime an assessment was			WILL CORRECT THE DEFICIENT PRACTICE	FOR THOSE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY
ANDPLANO	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG _		COMPLETED
p I		345206	B. WNG _			C 08/14/2014
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		34	TREET ADDRESS, CITY, STATE, ZIP CODE 45 MANOR ROAD MARS HILL, NC 28754	00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR AFFECTED BY THE DEFICIENCY	BE COMPLETION DATE
F 280	Continued From page	12	F 2	80	THOSE HAVING THE POTENTIAL TO BE	AFFECTED
	done. The MDS Coordinator stated the family member name written on the "invited" line of the sign in sheet is generated directly from the first emergency contact name from the resident's face				THE SYSTEMIC CHANGE OF ASSIGNIN	G THE SOCIAL
					WORKER THE RESPONSIBILITY OF RE	SIDENT AND
	sheet in the medical re Coordinator stated sh	ecord. The MDS e verified the name on the			FAMILY NOTIFICATION, REQUIRING	
	sign in sheet matched	I the resident's emergency ad no involvement in the			DOCUMENTATION OF NOTIFICATION	RESULTS AND
	process of inviting families or guardians to the meetings. The MDS Coordinator stated the				SCHEDULING OF THE INTERDISCIPLINA	ARY CARE
	receptionist did all of t			MEETINGS BASED ON THE 7 DAYS FOL	LOWING	
	The MDS coordinator			THE COMPLETION OF THE COMPREH	ENSIVE	
	care plan resident list went to the receptionist to send the postcard out, the care plan had already been developed by the interdisciplinary team.				ASSESSMENT AS WELL AS REQUIRING	THE OFFICE
	The MDS coordinator	stated the purpose of to families or guardians			MANAGER TO UPDATE THE FACILITY C	OMPUTERIZED
	was to give them a ch	ance to express their desire			FACE SHEET AS CHANGES BECOME KN	NI NWC
	The MDS coordinator	care plan with someone. stated if a family called to			RESPONSIBLE PARTIES AND INTEREST	ED FAMILY
	or another staff person	ntor would appoint a nurse n to meet with the family			AND THOSE WHO WANT INVOLVEME	NT IN THE
	MDS Coordinator stat				PROCESS HAS CREATED THE MEASURI	:WHICH PUTS
	working there.	the 3 years she had been			INTO PLACE THE CHANGE WHICH WIL	L PREVENT
		dmitted to the facility on			THE DEFICIENT PRACTICE FROM OCC	JRRING. THE
		seizures, and gallstones.			REVISION IN THE FACILITY QUALITY A	SSURANCE
	Data Set (MDS) dated	cent quarterly Minimum 106/24/14 assessed her as			PROGRAM WILL CREATE INTERNALM	ONITORING
	#6's family was listed	nitively impaired. Resident as her responsible person			DATES OF CARE PLAN NOTIFICATION	S, OF
	in her medical record.				ACTUAL MEETINGS AND REVISIONS	TO FACE
	Review of facility Inter Attendance Sign-in for				SHEET INFORMATION WILL CREATE	THE INTERNAL

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
l _s			-		С
		345206	B. WNG		08/14/2014
540050000000000000000000000000000000000	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION	345 1	EET ADDRÉSS, CITY, STATE, ZIP CODE MANOR ROAD RS HILL, NC 28754	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 280	member signatures wattendance sign in shall neview with family in 08/11/14 at 3:25 PM in been invited to a care participate in the care during the 5 years Refacility. Interview with facility 08/13/14 at 4:39 PM in handled all responsible participate in the swarp stated the reinvitation post cards the first contact of the factorecord. When asked listed as invited on the sheet, the SW stated in sheet was generate who also listed the perion on the face sheet in the sign in sheet. The SW Coordinator was not inviting the resident's the contact person's in meeting sign in sheet. Interview with facility 10:23 AM revealed sheet in the sidn in sheet was generated in the contact person's in meeting sign in sheet. Interview with facility 10:23 AM revealed sheet in the sidn in sheet weekly who plan meetings. When receptionist stated sheet in the sidn in sheet in the contact person's in meeting sign in sheet. Interview with facility 10:23 AM revealed sheet in the sidn in sheet in sheet in the contact person's in meeting sign in sheet. Interview with facility 10:23 AM revealed sheet in the contact person's in meetings. When receptionist stated sheet in the contact person in sheet. In the contact person in sheet. The sidn in the contact person in sheet.	tings were 10/23/13, nd 07/08/14. No family were on any of the care plan eets. member of Resident #6 on revealed she had never planning meeting or to plan development process esident #6 had been at the social worker (SW) on revealed the receptionist illities of inviting residents es to care plan meetings. ceptionist mailed out to the address listed in the resheet from the medical about the family member es care plan meeting sign in the care plan meeting sign ed by the MDS Coordinator, erson named as first contact the medical record on the W stated the MDS involved with the process of contact person, but listed name on the care plan receptionist on 08/14/14 at the was given a list of were scheduled for care	F 280		

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OLIVIUI.	to r orthicalornic a	MEDIONIO CENTICES				OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345206	B. WNG			C 08/14/2014	
	ROVIDER OR SUPPLIER	ITATION		345 1	EET ADDRESS, CITY, STATE, ZIP CODE MANOR ROAD RS HILL, NC 28754	1, 00/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	989	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 280	documentation kept receptionist provided included the name of had sent cards out or stated she did not know the facily Plan attendance sign which stated the date and sent cards out or stated the name of had sent cards out or stated she did not know the facil Plan attendance sign which stated the date and asked why she hos/02/14 and not beforeceptionist stated she recipionist stated she card and asked why she hos/02/14 and not beforeceptionist stated she residents to send card plan meeting was conhave the plan reviewed mailed to them. Interview with the MD at 2:58 PM revealed sinterdisciplinary care each resident wheney	ist stated there was no egarding family response to wup was done to ensure and received the post card. Ided one of the cards that members/contacts. The he address of the facility ename and address of the nily. The back of the card abers care plan had been se call the Receptionist to time or the care plan could y. The bottom of the card acility and the phone refacility. Interview on 08/14/14 the alist of residents, which Resident #6, for whom she to 05/02/14. The receptionist ow if the family of Resident and she had no response from them. Ity Interdisciplinary Care in form for Resident #6, of meeting was 04/14/14, and mailed out the card on one the meeting, the ewas given a list of its out for once their care inpleted to invite them to ad with them or have it	F	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
1		345206	B. WNG				C
	ROVIDER OR SUPPLIER		b, viiito	3	STREET ADDRESS, CITY, STATE, ZIP CODE 845 MANOR ROAD WARS HILL, NC 28754	08/	/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	done. The MDS Coor member name written sign in sheet is gener emergency contact not sheet in the medical rocordinator stated she sign in sheet matched contact person, but he process of inviting fan meetings. The MDS receptionist did all of list of all residents who The MDS coordinator care plan resident list send the postcard out been developed by the The MDS coordinator sending the post card was to give them a charton to review the revised of the MDS coordinator do this, the Administrator another staff person member or guardian to MDS Coordinator staff callity's procedure for working there. 3. Resident #162 was 11/19/13 with diagnoss disease, vascular den Resident #162's most Data Set (MDS) dated being cognitively intact #162's medical record was listed as Resident contact, and Resident	time an assessment was redinator stated the family on the "invited" line of the ated directly from the first ame from the resident's face ecord. The MDS everified the name on the atthe resident's emergency and no involvement in the nilies or guardians to the Coordinator stated the chat once she was given a contact had a care plan revision. In stated once the updated went to the receptionist to the care plan had already even interdisciplinary team. In stated the purpose of the to families or guardians ance to express their desire care plan with someone. In the meet with the family or review the care plan. The	F	280			

The state of the s		VICTORID GERVIOLG			Status exert 5th etitaethers statisticheren	I	J. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	ACCOUNT OF STREET	SURVEY PLETED
		345206	B. WNG			ı	C
NAME OF D	ROVIDER OR SUPPLIER	343200	D. MINO		STREET ADDRESS, CITY, STATE, ZIP CODE	08	/14/2014
	HEALTH AND REHABIL	ITATION		3	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCY)			(X5) COMPLETION DATE
F 280	Attendance Sign-in for revealed date of meet 01/07/14. No family in signatures were on an attendance sign in she interview with the Adm 08/13/14 at 3:57 PM in admissions, she assis with completing the fir contact information she staff when notifying fachanges in condition a care plan meetings. Tresident with a legal guardianship papers with the signal of the staff with the signal of the sign	rdisciplinary Care Plan rm for Resident #162, rings were 10/13/13 and nember or guardian ny of the care plan eets. nissions Director (AD) on evealed during all sted residents and families est, second, and third neet, which was used by all	F	280			
	Interview with the legal on 08/13/14 at 4:14 P been invited to attend participate in the care since Resident #162's The guardian of Resident Resident #162's stay at the facility and with the legal docume the time of Resident #facility. The guardian Resident #162's stay a guardianship status has permanent, but no oth made.	ad changed from interim to er changes had been					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345206	B. WING _			C /14/2014	
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754	1 00	11412014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	and responsible partie. The SW stated the recinvitation post cards to first contact of the face record. When asked a listed as invited on the sheet, the SW stated in sheet was generate who also listed the peon the face sheet in the sign in sheet. The SW Coordinator was not in inviting the resident's at the contact person's in meeting sign in sheet. Interview with Office MAM revealed facility has papers during Residen asked why the guardia been listed as the first face sheet, the office in thought that the guard had been revoked at some strength of the face in the office manager strength and been revoked at some strength of the face in the office manager strength of the office manager strength of the face in the office manager strength of the office manager strengt	es to care plan meetings. Deptionist mailed out of the address listed in the esheet from the medical about the family member of care plan meeting sign in the care plan meeting sign in the care plan meeting sign in the care plan meeting sign and by the MDS Coordinator, arson named as first contact the medical record on the vistated the MDS involved with the process of contact person, but listed ame on the care plan. Manager on 08/14/14 at 8:05 and been given guardianship in the fac's admission. When an of Resident #162 had not contact on Resident #162 had not contact on Resident #162 had not acontact on Resident #162 had not contact to the first had not conta	F 2	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		Change to Change to Change				9	С
		345206	B. WNG			08/	14/2014
The CAS COST OF CAS	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		34	REET ADDRESS, CITY, STATE, ZIP CODE 5 MANOR ROAD ARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	the family members here the receptionist provious sent out to family front of the card has the resident's contact/family stated the family memore viewed and to please arrange a conference be mailed to the family had the name of the finumbers to contact the fundation of the contact that the cont	w up was done to ensure ad received the post card. ded one of the cards that members/contacts. The he address of the facility aname and address of the facility. The back of the card abers care plan had been se call the Receptionist to time or the care plan could y. The bottom of the card acility and the phone is facility. Interview on 08/14/14 the a list of residents, which Resident #162, for whom ut on 01/06/14. The is card had been sent to be ymember who was listed irst emergency contact and when asked why she had the resident's guardian, the is had been told to only mail me listed in the first the face sheet. The is did not know if the family sived the card and she had any response from them. It is listed in the first in form for Resident #162, of meeting was 01/07/14, and mailed out the card on mough time before the to attend, the receptionist a list of residents to send ir care plan was completed the plan reviewed with	F	280			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345206	B. WNG		5 // 17		C
	ROVIDER OR SUPPLIER HEALTH AND REHABIL			3	STREET ADDRESS, CITY, STATE, ZIP CODE 45 MANOR ROAD MARS HILL, NC 28754	J 06.	/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	at 2:58 PM revealed sinterdisciplinary care peach resident whenever needed: quarterly, which ange, or any other to done. The MDS Coordinator stated shaign in sheet was genemergency contact near sheet in the medical recordinator stated shaign in sheet matched contact person, but he process of inviting fammeetings. The MDS creceptionist did all of the list of all residents have the MDS coordinator care plan resident were send the postcard out been developed by the The MDS coordinator sending the post card was to give them a che to review the revised of The MDS coordinator do this, the Administrator another staff person member or guardian to MDS Coordinator state facility's procedure for	S Coordinator on 08/14/14 the generated the clan attendance sheet for ver a care plan revision was men there was a significant time an assessment was rdinator stated the family on the "invited" line of the erated directly by the first ame from the resident's face ecord. The MDS e verified the name on the I the resident's emergency ad no involvement in the milies or guardians to the Coordinator stated the hat once she was given a ving a care plan revision. stated once the updated int goes to the receptionist to inthe care plan had already the interdisciplinary team. stated the purpose of to families or guardians ance to express their desire care plan with someone. stated if a family called to intor would appoint a nurse in to meet with the family or review the care plan. The	F	THE	312 483;25 ADL CARE PROVIDED FOR DEPENDEN FACILITY WILL PROVIDE THE NECESSARY SERVIC	ES 09/11	
F 312 SS=D	working there. 483.25(a)(3) ADL CAF DEPENDENT RESIDE A resident who is unab		Fí	312	MAINTAIN GOOD NUTRITION, GROOMING AND		

	STATEMEN	T OF DEFICIENCIES						VO. 0938-039
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
			345206	B. WNG				С
		PROVIDER OR SUPPLIER N HEALTH AND REHABILI			8	STREET ADDRESS, CITY, STATE, ZIP CODE	0	8/14/2014
-						MARS HILL, NC 28754		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS 和社会教授的企业扩充CTINE 从海角设计 DEFICIENCY)	DE	(X5) COMPLETION DATE
	F 312	0				THE ONE NAIL IN QUESTION DURING EXIT	ONFERENC	4
	1 012	daily living receives the	necessary services to	F3	312	OF RESIDENT #115 WAS CUT ON 08/13/14.	;	
	maintain good nutrition and oral hygiene.			THE RESIDENT NAIL CARE PROCEDURE WILL	. BE REVISEC			
					THE SHOWER TEAM C.N.A.'S ARE RESPONS			
		This REQUIREMENT	is not met as evidenced			DAILY NAIL CARE BUT NOW PERFORM NAIL		Ĺ
		by: Based on observations			RESIDENTS NOTED ON DAILY SHOWER LIST A	FTER THE		
		and family interviews the nail care to 1 of 5 samp		Ì	SHOWERS ARE COMPLETED FOR THE SHIFT.	THIS		
		activities of daily living			CHANGE IN NAIL CARE PROCEDURE WILL RE	DUCE		
		The findings included:				THE NUMBER OF ADL FUNCTIONS THAT MUS	T BE	
		Resident #115 was adm	nitted on 02/27/14 with			PROVIDED DURING THE SHOWER-BATHING		
		diagnosis which include weakness and lack of co	oordination. The most			EXPERIENCE AND WILL ALLOW MORE INDIVID	UALIZED	
		05/12/14 revealed Resid	m Data Set (MDS) dated dent #115 was severely			NAIL CARE. THE SHOWER TEAM DAILY ASSIGN	MENT	
		was usually understood.	I had unclear speech but The MDS further			SHEET WILL BE REVISED TO INCLUDE COMME	NTS	
	1	revealed Resident #115 assistance from staff for	required extensive			ON RESIDENT NAIL CONDITION. THE DIRECTOR	₹OF	
		personal hygiene. Resident not being resistive to care	dent #115 was coded as			NURSING WILL REVIEW THE CHANGES IN SHO	WER	
						TEAM RESPONSIBIITIES AND NAIL PROCEDUR	ES	
		A care plan dated 03/19/ #115 required extensive	2 person assistance with			IN A MANDATORY C.N.A. AND NURSE		
		Resident #115 would be	care. The goal stated able to participate in part			INSERVICE. THE JOB DESCRIPTION		1
	1	The ADL care plan include	t review date of 08/19/14. ded approaches to assist			OF THE NURSE MANAGERS WILL BE REVISED		
		rtesident #115 by breakii steps, allowing rest breal	ng tasks up into smaller ks between tasks, talking			TO INCLUDE THE RESPONSIBILITY OF DAILY		
	'	with resident while provir and trust along with givin prompt,	ng care to build rapport			MONITORING OF NAIL CARE AND DAILY SHOW	VER	
	11			1	1		F .	10

DEPAR	RTMENT OF HEALTH AN	ID HUMAN SERVICES			F		D: 08/28/20	
STATEMEN	ERS FOR MEDICARE &						M APPROVI 0. 0938-03	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPTRICTION	(X3) DATE	E SURVEY PLETED	91
		345206	B. WNG				С	
NAME OF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	08/14/2014		
MADISO	N HEALTH AND REHABILI	TATION			45 MANOR ROAD			
					IARS HILL, NC 28754			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	=	(X6) COMPLETION DATE	
F 312	A review of a nurse aid	le assignment sheet dated	FS	312	TEAM DOCUMENTATION FORM WILL BE REVIS	ED		1
	08/11/14 through 08/18	5/14 identified Resident wers on Wednesdays and			TO MORE CLEARLY DENOTE THOSE RESIDENT'S	TE THOSE RESIDENT'S		
	Fridays.	wers on wednesdays and			PROVIDED NAIL CARE AS WELL AS A COMMEN	т		
	During an observation	ng an observation on 08/11/14 at 11:04 AM			SECTION ON NAIL CONDITION.			
	revealed Resident #11st dark colored debris und	5 had 10 fingernalls with			THE FACILITY QUALITY ASSURANCE PROGRAM			
		on 08/12/14 at 11:51 AM			WILL BE REVISED TO INCLUDE MONITORING OF	=		
	revealed Resident #115 dark colored debris und	had 10 fingernalls with			THE SHOWER TEAM DOCUMENTATION-			
	371 374 375 375 375 375 375 375 375 375 375 375	on 08/12/14 at 3:45 PM			-FOR 4 WEEKS AND THEN MONTHLY			
	revealed Resident #115 dark colored debris und	had 10 fingernalls with			ON NAIL CARE AND THE MONITORING OF			
9	District of the state of	20 X			THE NURSE MANAGER'S MONITORING OF THE			
	revealed Resident #115	n 08/13/14 at 10:00 AM returned to her room			DAILY NAIL CARE. THE CORRECTION ACTION			
	had 10 fingernails with o	h Nurse Aide (NA) #5 and dark colored debris under		Ē	OF CUTTING RESIDENT #115'S			
	:				FINGERNAIL AND THE CORRECTIVE ACTIONS			
1	Resident #115's family re	8/12/14 at 11:46 AM with evealed they would like		ĺ	INVOLVED IN REVISING THE NAIL CARE PROCED	OURES,		
	for her nails to be cleane would be more sanitary.	ed because they felt this			REVISING THE SHOWER TEAM NAIL CARE			
	During an interview on 0	8/13/14 at 10:46 414			DOCUMENTATION FORM AND ASSIGNING THE			1
1	NA #5 who was familiar what assisted with her sho	8/13/14 at 10:16 AM with with Resident #115 and			NURSE MANAGERS THE RESPONSIBILITY OF			
1	system for showers. NA	#5 stated she looked at			MONITORING DAILY NAIL CARE WILL RESOLVE			
	the residents who would	ch day and made note of be getting showers that			THE DEFICIENT PRACTICE FOR THE RESIDENT			

day. NA #5 continued by stating nails would get

fingernails if they had debris under them. NA #5 confirmed Resident #115 was complete with her

shower when she brought her back to her room.

clipped and filed along with cleaning the

AFFECTED AND THOSE RESIDENTS HAVING THE

POTENTIAL TO BE AFFECTED. THE SYSTEMIC

CHANGE OF PROVIDING NAIL CARE SEPARATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/28/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED C 345206 B. WING NAME OF PROVIDER OR SUPPLIER 08/14/2014 STREET ADDRESS, CITY, STATE, ZIP CODE MADISON HEALTH AND REHABILITATION 345 MANOR ROAD MARS HILL, NC 28754 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 22 F 312 NA #5 concluded she had noticed the debris under Resident #115 nails and was not able to REVISING THE SHOWER TEAM DOCUMENTATION get it cleaned out. FORM TO INCLUDE MORE INFORMATION ON During an interview on 08/13/14 at 10:53 AM with Nurse #1 stated she was familiar with the care of NAIL CARE CONDITIONS WILL CREATE THE CHANGE Resident #115. Nurse #1 stated it was her expectation that resident's nails were clean and THAT WILL ENSURE THE DEFICIENT PRACTICE WILL this was part of the shower routine. Nurse #1 confirmed that Resident #115's nails did need to NOT OCCUR. THE DAILY MONITORING OF RESIDENT be cleaned and she would get a nurse aide to NAIL CARE BY THE NURSE MANAGERS AND THE clean them. REVISION OF THE FACILITY QUALITY ASSURANCE During a follow-up interview on 08/13/14 at 11:18 AM with Nurse #1 she stated Resident #115's PROGRAM TO MONITOR THESE SYSTEM CHANGES nails were clean and Resident #115 had allowed them to clean her nails. WILL CREATE THE INTERNAL MONITORING PLAN During an interview on 08/14/14 at 4:33 PM with WHICH WILL ENSURE THE SOLUTIONS ARE the Director of Nursing (DON) she explained nail care should be provided during the shower. The SUSTAINED DON further stated they had some staff on light duty who worked on nail care every day. The DON concluded by stating it was her expectation that debris under nails be cleaned because it should not be there. F 371 483.35(i) FOOD PROCURE, F 371 STORE/PREPARE/SERVE - SANITARY SS=E The facility must -F371 483:35 FOOD PROCEDURE=STORE/PREPARE/ (1) Procure food from sources approved or considered satisfactory by Federal, State or local SERVE SANITARY 09/11/14 authorities; and (2) Store, prepare, distribute and serve food THE FACILITY WILL PROCURE FOOD FROM SOURCES under sanitary conditions APPROVED AND CONSIDERED SATISFACTORY BY FEDERAL, STATE OF LOCAL AUTHORITIES AND STORE

PREPARE, DISTRIBUTE AND SERVE FOOD UNDER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		345206	B. WNG			08/	C 14/2014
19	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		,	STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	23	F:	371			
					THE PROCEDURE FOR CLEANING THE P	ANTRY	
	This REQUIREMENT is not met as evidenced by:				REFRIGERATORS WILL BE REVISED. TH		
		ns, record review, and staff			DESCRIPTION OF THE DIETARY AIDE W	DIETARY AIDE WILL BE	
	cleanliness in 1 of 2 p				REVISED TO INCLUDE THE DAILY CLEAR	JDE THE DAILY CLEANING	
	The findings included	!			OF ALL PANTRY REFRIGERATORS BEFC	RE THE	
	A review of an undated Job Description for Night Shift Nurses was conducted. Included in duties				2:PM SNACKS ARE TAKEN TO THE NUF	RSING	
	of the night shift nurse			UNIT. ALL DIETARY STAFF WILL BE INS	ERVICED		
	refrigerator in the pan	e the nurse aides cleaned the large rator in the pantry rooms every Monday			ON THIS CLEANING PROCEDURE BY T	HE FSM.	
	night.				THE INSERVICE WILL BE INCLUDED IN	THE	
		n 08/11/14 at 9:33 AM n the south pantry room			DIETARY JOB SPECIFIC ORIENTATION		
		a raised ping pong ball size on the floor of the freezer.			THE JOB DESCRIPTION OF THE FOOD	SERVICE	
		rigerator contained a reddish alf of the top of the shelf			MANAGER WILL BE REVISED TO INCL	UDE THE	
	•	n. The substance was sticky pill extended from the front			RESPONSIBILITY OF MONITORING TH	IE	
	edge to approximately	y mid way across the bin. A atter was observed in front of			CLEANLINESS OF THE PANTRY REFRI	GERATORS	·.
	the right front of the v	egetable bin and extended mately half of the depth of			THE Q.A. PROGRAM WILL BE REVISE	D TO	
		tor contained juices and			INCLUDE DAILY MONITORING OF P.	ANTRY	
		servation on 08/12/14 at			CLEANLINESS FOR 2 WEEKS AND T	HEN WEEK	LY
	11:22 AM revealed a	tray of sandwiches, juices,			MONITORING FOR 4 WEEKS. MON	VEEKS. MONTHLY	
	use was placed over	ments labeled for resident the sticky splatter on the			CHECKS BY THE Q.A. COORDINATO	OR IN THE	
	shelf over the vegetal were unchanged in a	egetable bin. The other spills d in appearance.		FACILITY Q.A. PROGRAM THER		TER. THE	
					PANTRY REFRIGERATOR WAS CLEA	NED 8/13	/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345206	B. WING		C 08/14/2014		
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION				3	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 371	Continued From page 24 1c. Continued observations on 08/13/14 at 7:50 AM and 3:15 PM revealed the soiled areas in the south pantry refrigerator were unchanged.		F	371	THIS CORRECTIVE ACTION AND THE		
							E
					JOB DESCRIPTION OF THE DIETARY	AIDE TO	
	Unit Manager (UM) #1 participated in the observation of the south pantry refrigerator on 08/13/14 at 3:15 PM. UM #1 acknowledged the refrigerator should be cleaned. She stated she				INCLUDE DAILY CLEANING OF PAN	3 OF PANTRY	
					REFRIGERATORS AND THE INSERVI	CING OF	
	thought it was the responsibility of the night shift nurse aide to clean the refrigerator. UM #1 was unsure who monitored the nurse aides to see this was done.				DIETARY STAFF IN THIS NEW RESPO	NSIBILITY	
					NOTED ON THE DAILY CLEANING A	ASSIGNMENT	
	An interview with the Director of Nursing (DON) on 08/14/14 at 4:46 PM revealed the night nurse aides were supposed to clean the pantry refrigerators on Monday nights. The DON stated it was her expectation this task would be				AND THE FSM'S RESPONSIBILITY IN		3
					WILL RESOLVE THE DEFICIENT PRAC		
					THE RESIDENT AFFECTED AND THO: THE POTENTIAL TO BE AFFECTED A		
	completed so the retri	gerator remained clean.			CREATE THE SYSTEMIC CHANGE W		
	5.				ENSURE THE DEFICIENT PRACTICE		3
					OCCUR. THE REVISION OF THE FACI		
					QUALITY ASSURANCE PROGRAM TO	о моніто	R
					THE CLEANLINESS OF PANTRY REFF	RIGERATORS	
					DAILY, WEEKLY AND THEN MONTH	нц	
					WILL CREATE THE INTERNAL MONI	FORING PL	AN
					TO MAKE SURE THE SOLUTIONS ARE	LUTIONS ARE SUSTAINED.	