PRINTED: 11/25/2011 FORM APPROVED

AMENDED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 345206 B. WNG 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MADISON HEALTH AND REHABILITATION MARS HILL, NC 28754 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 An amended Statement of Deficiencies was provided to the facility on 11/20/15 because information submitted during the IDR process made it necessary to correct the language of the practice statement for tag F-323. Event ID# YGMI11. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 F282 10/15/15 PERSONS/PER CARE PLAN SS=G Disclaimer Clause: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of Madison Health and Rehab care. requests to have this Plan of This REQUIREMENT is not met as evidenced Correction serve as our written allegation of compliance. Our Based on record review and staff interviews the facility failed to follow care plan guide alleged date of compliance is intervention of mechanical lift transfer which resulted in 1 of 6 sampled residents (Resident October 15, 2015. Preparation #27), sustaining a fracture. and or execution of this plan Findings included: does not constitute admission The quarterly Minimum Data set (MDS) dated to nor agreement with either 08/03/15 revealed Resident #27 was admitted to the facility on 08/07/11 and was severely the existence of, or scope and cognitively impaired. Resident #27 was diagnosed with dementia, anxiety disorder, severity of any of the cited severe osteoporosis, and depression. Resident #27 required extensive assistance with bed deficiencies, or conclusions set mobility and dressing with 2 plus person physical assistance. Resident #27 was totally dependent forth in the statement of on staff with transfers, personal hygiene, and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

sam anner

bathing and required 2 plus person physical

deficiencies. The plan is

(X6) DATE

10/13/2015

Any deficiency statement ending with an asterist (\*) 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) Excaption horsing 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. GEC 0 3 2015

assistance.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/25/2013 FORM APPROVED

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 10 98	IPLE CONSTRU		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER I HEALTH AND REHABIL	ITATION		345 MANOR	RESS, CITY, STATE, ZIP CODE ROAD -, NC 28754	1 03	71772013
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	Resident #27's care p self-care deficit. Resident sassistance with bed massistance with mechatransfers. Resident #2 of at risk for falls with required mechanical lifor intentional transfer. The nurse aide care g revealed Resident #27 activities of daily living mechanical lift with tra. The incident report da Resident #27 had a fa with no head injury and minor harm. Narrative Resident #27 was transassisted by nurse aide pad slid from chair whis sliding out of adaptive Resident #27's right le position. Resident #27 backboard and legs we and gait belt onto the backboard and legs we and gait belt onto the backboard (ER) transport (EMS) for an The physician's order of "Send resident to ER days the self-care to the hospital emergency for the formal factors and the factors are the factors and the factors ar	lan revealed a problem of lent #27 required 2 person arobility and 2 person anical lift for intentional 17 had an identified problem severe osteoporosis and ft with 2 person assistance s.  uide for August 2015 7 required total care with 1. Resident #27 required nsfers.  ted 08/15/15 revealed 18 on 08/15/15 at 11:31 AM 18 d was documented as incident note revealed sferred to adaptive chair (NA) #1 and positioning ch resulted in Resident #27 chair onto NA #1's lap. 18 g was in an unusual was placed on a pere stabilized with a pillow backboard. On 08/15/15 at 17 was transported to the via emergency medical	F2	er w re Ro gu st ao N p fo n ir N p	repared and executed as sure continuing compith Federal and State and gulatory law.  esident # 27's care playide and current transtatus was reviewed for curancy by the Directory of the surrocess. All information of the surrocess. All information of the surrocess of the Directory of the Directory of the Directory of the Directory of the Surrocess, on following of the surrocess, on following of the surrocess, on following of the surrocess.  In audit was complete the surrocess of the surrocess of the surrocess of the surrocess.  In audit was complete the surrocess of the surrocess	an, cansfer or of the cated actor of the cated acto	re and f

The nurse's note dated 08/15/15 at 12:05 PM

STATEMENT	OF DEFICIENCIES	OWN PROVIDED OUT TO THE	T			OMR MC	0. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER		]		TOTAL ADDRESS SITUATION	09/	17/2015
			STREET ADDRESS, CITY, STATE, ZIP CODE				
MADISON	HEALTH AND REHABIL	ITATION	345 MANOR ROAD				
WW ID	STIMMADY OT	TENENT OF DEFINITION		IV	MARS HILL, NC 28754		
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F 282	Continued From page 2		F	282	Quality Assurance Coo	rdinat	or
	revealed Resident #27 was transferred from bed to chair by NA #1 and the pad under Resident				during the survey proc	ess to	
	#27 slipped out of cha	air and resident slipped to			ensure the continued		
	#1's lap with legs in st	range position. Resident			compliance for all resid	dents	
*	#27's legs were stabilized with pillow and gait belt onto a backboard. EMS was summoned for				requiring the use of a		
	transport.				mechanical lift for tran	isfers,	
	On 09/15/15 at 4:30 PM an interview was conducted with NA #1 who stated she should			according to the most		nt	
	have used the mechan	nical lift on 08/15/15 when nt #27 out of bed (OOB)			care plan assessment.		
	into the chair. NA #1 s	tated the nurse aide care			audit also included the	: revie	w
	guide indicated Reside mechanical lift for trans	sfers with 2 person			and updating of all Res	sident	
	get Resident #27 OOB	ed she was in a hurry to and rather than use the			Care Guides.		
	Resident #27 by herse	are guide she transferred If using a gait belt. NA #1			A daily monitoring too	l was	
	with transferring Resid	another NA for assistance ent #27 OOB. NA #1 stated			implemented on Septe	ember	.
		esident #27 but she did			18, 2015 by the Direct	tor of	
		NA #1 stated she knew able to bear any weight on			Nursing. The monitori	ng too	ol
	extremities but decided	to transfer resident by . NA#1 stated she had			will be completed by t	he DC	N
1,0	transferred Resident #2	27 into the chair and the ir and the cushion and the			or designated nursing	staff	
	resident slipped out of t	he chair. NA #1 stated she			member and includes		
	held Resident #27 as resident slid out of the chair. NA #1 stated she positioned herself behind Resident #27 to protect resident's head and guided Resident #27's head and body onto NA				updated by the Qualit	У	
					monitoring of nursing	1	
	#1's chest.	The state of the s			assistants performing		
	On 09/15/15 at 4:57 PM				appropriate transfers	using	

STATEME	NT OF DEFICIENCIES	(X1) BBOMBERGHER ISSUED			OMB NO	O. 0938-0391
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	F PROVIDER OR SUPPLIER ON HEALTH AND REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754	[09/	/17/2015
(X4) II PREFI TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	HOULD BE	(X5) COMPLETION DATE
F 28	required to pick up a conguide every day at the was included on the N stated a more detailed care guide for NAs that MDS was placed on a station for the NAs to guide interventions look sheet. NA #2 stated Rerequired a mechanical person assistance and indicated mechanical litransfers.  On 09/16/15 at 8:11 All conducted with the DO upon herself to transfer using the mechanical lit knew better than to train using the mechanical litworked at the facility fo NA #1 was provided dis following Resident #27' DON stated her expect would have followed Reand transferred residen 2 person assistance.  On 09/16/15 at 11:02 All conducted via phone with NA #1 transferred residen using the mechanical liftereceived care guide to obeginning of shift to indi	copy of the resident care be beginning of the shift which IA assignment sheet. NA #2 I individualized resident at was created from the clip board at each nurse's follow in addition to care stated on NA assignment esident #27 had always lift for all transfers with 2 I nurse aide care guide ift was required for all  If an interview was IN who stated NA #1 took it r Resident #27 without ft. The DON stated NA#1 insfer Resident #27 without ft because she had r a long time. DON stated sciplinary action for not s care guide for transfers. ations were that NA #1 esident #27's care guide t using mechanical lift with  If an interview was th Nurse #1 who stated ent #27 by herself without tt. Nurse #1 stated NA #1 earry with her at the cate how Resident #27 furse #1 stated NA #1 was sk for assistance from ransfer Resident #27 II #1 should have	F 28		vices esidents' All residents assessed the facility, for er status a ing. All es will dated by the Coordinatiate transferuing ervicing woulded to a during new tion, as ag annual	y, and ne or, er ill

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T			OMB N	IO. 0938-0391
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i i i i i i i i i i i i i i i i i i i	transferred resident sate on 09/16/15 at 11:46 was conducted with the stated she was called after the fall had occur stated Resident #27's awkward position and the leg. Weekend Man was placed on a backly immobilized to the backly weekend Manager stated from the physician to see ER for an evaluation. What is the had transported chair by herself without weekend Manager stated when weekend Manager stated when weekend Manager stated when weekend Manager stated when weekend massignment weekend massignment weekend massignment weekend with Nurse #27's care guide that in the betransferred.  On 9/16/15 at 12:21 PM conducted with Nurse #27's roommate was yet weekend was sitting ocated behind the residence was guide that indicated behind the residence was guident was g	AM a telephone interview e Weekend Manager who to Resident #27's room red. Weekend Manager right leg was in an physical therapy assessed ager stated Resident #27 to and and right leg was kboard using a gait belt. ted she received orders end Resident #27 to the Veekend Manager stated Resident #27 OOB to the using the mechanical lift. ted NA #1 informed that felt comfortable to by herself. Weekend NA #1 began shift she than a copy of Resident dicated how resident was  I an interview was 2 who stated Resident dicated how resident was  I an interview was 2 who stated Resident dicated how resident was  I an interview was 2 who stated Resident was  I an interview was 2 who stated Resident was was a control of the floor with NA #1 dent and was holding stated Resident #27 had ed resident required ensfers with 2 person ated NA #1 was provided as care guide at the curse #2 stated it was the of follow interventions on	F 2	82	Care Plans for all residence continue to be updated as needed, to ensure of compliance of the written of care.  The monitoring tools/will continue to be considered nursing at least ten percent of residents weekly for forweeks, then ten percent of the weeks, then ten percent of the audits to the Qual Assurance Performant Improvement commit monthly for review and the suddent of the commit monthly for review and the suddent of the commit monthly for review and the continue to be updated as a surance Performant Improvement commit monthly for review and the continue to be updated as needed, to ensure of the writing tools and the commit and the continue to be updated as needed, to ensure of the writing tools and the continue to be updated as needed, to ensure of the writing tools and the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing tools are the continue to be updated as needed, to ensure of the writing to the	audits audits mplete staff, total our ent of three of esults ity ce tee,	y, ued lan ed for

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NAME OF F	PROVIDER OR SUPPLIER			0.10557.100553	09/17/2015	_
	N HEALTH AND REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MARS HILL, NC 28754	8	
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;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	have followed care gu with 2 person assistant On 09/16/15 at 2:39 Pl conducted with NA #3 duty when Resident #27 NA #1 did not ask NA #1 transfer Resident #27 could have assisted NA Resident #27 OOB but NA #3 stated she was sheet at the beginning care guide information assignment sheet. NA #3 indicated if resident was mechanical lift.  On 09/16/15 at 2:52 PN conducted with NA #4 viduty the day Resident #3 stated she brought the equipment to Resident #3 stated she was available for assistance to transfer #4 stated she was available for assistance. Now #4 for assistance. Now #4 for assistance was available for the equipment for Resident #27 NA #1 for assistance. Now #4 stated she was available for the equipment for Resident #27 NA #1 for assistance. Now #4 for assistance was available for the equipment for the equipment for Resident #27 NA #1 for assistance. Now #4 stated she was available for the equipment for Resident #27 NA #1 for assistance. Now #4 for assistance for Resident #27 NA #1 for assistance was available for the equipment for the equipment for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #27 NA #1 for assistance was available for the equipment for Resident #	ide and used mechanical lift ce for transfer.  M an interview was who stated she was on 27 had a fall. NA #3 stated #3 for assistance to OOB. NA #3 stated she A #1 with transferring was not asked by NA #1. provided an assignment of shift with the resident's included on the #3 stated the care guide s to be transferred using a who stated she was on £27 had a fall. NA #4 backboard and vital sign #27's room after the fall. ot been asked by NA #1 or Resident #27 OOB. NA able to assist NA #1 with but was never asked by A #4 stated she received the beginning of shift that uide information on how  M an interview was inistrator who stated her IA #1 would have y for transferring have followed Resident	F 282			

		OF DEFINITIONS					OMB N	O. 0938-0391
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	NAME OF F	PROVIDER OR SUPPLIER	345206	B. WNG	_		09	/17/2015
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	F 315	Continued From	0			F315		
	F 315	minasa i rom pago		116	315	Disclaimer Clauses		
	SS=D	483,25(d) NO CATHET RESTORE BLADDER	IER, PREVENT UTI,	F 3	315	Discialifier Clause.		10/15/15
	00 0	94 - 2001 to 2 044 4968				Madison Health and Rehab re	enuests	to
		Based on the resident's	s comprehensive			have this Plan of Correction s		1
		assessment, the facility resident who enters the	/ must ensure that a e facility without an			written allegation of complian		
		indwelling catheter is n	ot catheterized unless the			alleged date of compliance is	1	_
resident's clinical condition demonstrates that catheterization was necessary; and a resident				15, 2015. Preparation and or	757 1 700-01700			
who is incontinent of bladder receives appropriate				of this plan does not constitu				
treatment and services to prevent urinary tract infections and to restore as much normal bladder				admission to nor agreement	- 1	ther		
		function as possible.	e as much normal plagger			the existence of, or scope and	d sever	ity
						of any of the cited deficiencie	s, or	7
		This REQUIREMENT i	s not met as evidenced			conclusions set forth in the statement		
		by:	, record reviews, resident,		of deficiencies. The plan is prepared			
		staff, and physician inte	rviews, the facility failed to			and executed to ensure conti	-	
	13	secure an indwelling uri	nary catheter tubing and			compliance with Federal and	State	
		reviewed for incontinend	er care for 2 of 2 residents ce care (Residents #77			regulatory law.		
	-	and #116).				Resident Found to be Affec	ted an	ıd
	-	The findings included:				Residents Having the Poter	ntial to	be
		() Desident #77				Affected		
		Kesident #// was re-     Masident #// was	admitted to the facility on which included multiple					
	j	oint contractures, muscl	e weakness, diabetes	1		All residents with an indwellir	ng uriha	ary
	n	nellitus, kidney failure, a	and urinary obstruction.			catheter were identified by th	ie Nurs	e
	h	nistory of urinary tract in	fections, and indwelling			Manager, during the survey p	rocess,	to
	N	ırinary catheter. A reviev Minimum Data Set (MDS	N of the most recent			ensure catheter tubing was se	cured	and
	ir	ndicated Resident #77 v	vas severely cognitively			catheter care was provided		
	ir w d	mpaired. The MDS also /as totally dependent on aily living (ADLs), had a atheter and was incontir	indicated Resident #77 staff for activities of n indwelling urinary			appropriately to prevent urin	ary tra	ct
	1	100404 4643704000 11465300 <del>0</del> 76.14814	nonconstruction The Company of the C				1	1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE			/17/2015
MADISON	HEALTH AND REHABIL	ITATION		34	IS MANOR ROAD ARS HILL, NC 28754		
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	Resident #77 had an related to neurogenic control) and had the prinfections. The goal syremain free of signs at tract infection. The appropriate and traction and tractions are after each inconting an observation. Nurse Aide (NA) #3 an incontinence care to be covering Resident #77 resident was lying on indwelling urinary cathwas turned to his right amount of soft brown resident's buttocks with appeared to be wet the side at which time Reshave another moderate stool. NA #3 was observed to caused the catheter turn (stretched) with no sland NA #3 was observed as the resident's perineal area.	n dated 06/19/13 indicated indwelling urinary catheter bladder (lack of bladder obtential for urinary tract pecified Resident #77 would not symptoms of urinary proaches included to g for kinks or twists in every shift, and perineal inent episode.  I on 09/16/15 at 9:40 AM, and Nurse #5 provided Resident #77. The sheet was removed and the a protective pad with an eleter in place. Resident #77 is side and had a moderate shool. NA #3 wiped the h wash cloths that en turned him on his left sident #77 was observed to be amount of soft brown erved to place the urinary the resident's heel he foot of the bed which bing to become taut ck in the catheter tubing. It wipe the male	F3	315	infections and to restore normal bladder function During the survey proces and #116 were assessed Manager and the Regions Clinical Services (RDCS) to appropriate indwelling ur placement and securing cindeed in place. Education inservicing for Nurse #5 a #3 was provided by the D Nursing and the RDCS on 2015. The education and included the use of approsecuring devices for indweatheters and incontinent residents' with said cathethe prevention of urinary infections and to restore a normal bladder function a systemic Change  Nurse #5 and Nurse Aide is devices for some residents.	as possible s, Resident by the Nurs al Director o ensure inary cathe levices were n and nd Nurse A irector of September inservicing priate elling urina care for ters to ensure tract as much as possible.	#77 se of eter e ide 17, ry
	#77's urinary catheter tubing revealed it was not secured to prevent tension on the tubing.  During an interview on 09/16/15 at 10:45 AM, NA #3 verified Resident #77 did not have his catheter				current device (Cath-secu always remain in place ap		
		NA #3 stated she did not	1			3	1

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER		Joseph Marine		TREET ADDRESS, CITY, STATE, ZIP CODE	09	/17/2015
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E 045	_				various residents. An alterna	tive	
F 315	Pago		F:	315	catheter securing device was	made	
	around his urinary cat	ront perineal area or clean heter because the urinary			available and implemented o	n	
catheter had already been cleaned earlier morning. She explained she knew she sho have cleaned his front perineal area and ar the catheter but she was not sure if she corclean his buttocks and then go to the front clean around the penis and catheter.		een cleaned earlier that			September 18, 2015, (cloth-	ike	
		ed she knew she should			catheter leg band). Inservicir	g for	
		perineal area and around as not sure if she could			appropriate indwelling urina	ry cathe	ter
		then go to the front to			care, and the use of catheter	of catheter securing	
		s and catheter.			devices was provided by the	Directo	rof
	During an interview on	09/16/15 at 10:50 AM,			Nursing, to all nursing staff n	nember:	son
	Nurse #5 stated Resident #77 had never had his catheter tubing secured to prevent tension on the				October 13,2015. A catheter	monito	ring
	tubing and she was un	d to prevent tension on the aware of what should be			tool was implemented by the	Directo	or
	used to secure the cath	neter tubing since they did			of Nursing on September 18,		
	not use tape. Nurse #5	further stated she would		1	ensure ongoing compliance of	2000	
	secured.	eter tubing to have been			residents with indwelling uri		
	B .				catheters will receive treatm	ent and	
	Unit Manager stated sh	09/16/15 at 3:05 PM, the se expected all resident's			services to prevent urinary tr	act	
	with an indwelling urina	ry catheter to have the			infections and to restore as n	nuch	
	tubing secured and to b	be cleaned around the			normal bladder function as p	ossible	All
	urinary catheter during	incontinence care.			residents who were identified	d to hay	e
	During an interview on	09/17/15 at 3:25 PM, the			an indwelling urinary cathete	r receiv	ed
	an indwelling urinary ca	pected all residents with			a physician's order to ensure	placem	ent
		a during incontinence care			of appropriate catheter secui		
	and to have the cathete	r tubing secured in place.			two times each eight hour sh	1000	
	During an interview on (	09/17/15 at 4:20 PM, the			September 24, 2015. The said		
	Director of Nursing (DO	N) stated it was her			were placed on the idenified		1
	expectation for staff to fe	ollow the facility policy			Medication Administration Re		
1	and clean a resident du with soap and water. Th	e DON further stated she			The Director of Nursing or de		4
	expected staff to clean a	around the urinary			nursing staff member will mo	8	
	catheters and the perine	eal area during			Will III		
(	incontinence care. The I expected all residents w	ith an indwelling urinary					

STATEMEN	T OF DEFICIENCIES	I	T		OMB NO. 0938-0391	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345206	B. WING		С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/17/2015	
MADICO	NIITALTII AND DELLA		1	345 MANOR ROAD		
MADISO	N HEALTH AND REHABILI	TATION	1	MARS HILL, NC 28754		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		popularity and the second seco		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE COMPLETION DATE	
E 0.45				MAR's for appropriate docu	ımentation	
F 315	Tom page		F 315	using the catheter monitor	ng tool.	
	catheter to have the tubing secured.		1			
				Monitoring		
	03/30/15 with diagnose	admitted to the facility on es which included		All residents will continue to	o receive	
	Parkinson's disease, u	rinary retention, pressure		assessments for incontinen	ce and	
ulcers, and urinary tract infection. A review of the most recent Minimum Data Set (MDS) dated		ct infection. A review of the Data Set (MDS) dated		indwelling urinary catheters		
	09/01/15 indicated Res	sident #116 was cognitively		admission, quarterly and a	as needed	
	intact and was capable	of making his needs		with any change in conditio	h any change in condition, to ensure propriate treatment and services are	
	required extensive ass	indicated Resident #116		appropriate treatment and		
mobility and was totally dependent on staff for all provided. Continued monitoring		oring of all				
	other activities of daily	living (ADLs). The MDS		residents' with an indwellin		
	bowel and had an indw	#116 was incontinent of		catheter will be provided by		
	Auto 1594 ou			Director of Nursing or desig	1 1	
	A review of a care plan	dated 04/13/15 Resident		nursing staff member. All ca		
	and the goal was to ren	for urinary tract infections nain free of urinary tract		related monitoring tools wil	1 1	
	infections. The approac	hes included to secure		daily for two weeks, then we		
	the catheter tubing to p	revent pulling or tension.		four weeks, then monthly u		
	to monitor the tubing for straighten the tubing as	r kinks or twists, to needed to ensure proper		notice. The Director of Nurs		
	drainage, and provide of	atheter care every shift.				
1	During on charactics	00//0//5		maintain and present all fin		
	During an observation of Nurse Aide (NA) #3 and	n 09/16/15 at 1:50 PM, Nurse #5 provided		Quality Assurance Performa		
	incontinence care to Re	sident #116. The sheet	1 1	Improvement committee du	(A) (A) (A) (A)	
	covering Resident #116	was removed and the	1	monthly QAPI meetings for i	eview	
1	resident was lying on a	protective pad with an	1	recommendations for contin	ued	
-	indwelling urinary cathet	er in place. Resident		compliance.		
	# 110 was turned to his r	ight side and had a small		and the second		
	amount of brown stool. It resident's buttocks with	NA #3 Wiped the				
	appeared to be wet then	turned him on his laft				
	side at which time cause	ed the catheter tubing to				
	pecome taut (stretched)	with no slack in the				
(	catheter tubing. NA #3 w	as observed to wipe				

MADISON HEALTH AND REHABILITATION 345 MANOR ROAD	C 09/17/2015  CITY, STATE, ZIP CODE  28754  VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE  COMPLETION DATE	-
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, OR MADISON HEALTH AND REHABILITATION  345 MANOR ROAD	28754  VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE COMPLETION	
MADISON HEALTH AND REHABILITATION 345 MANOR ROAD	28754  VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE COMPLETION	I
MARS HILL, NC 2	CORRECTIVE ACTION SHOULD BE COMPLETION	
TACK (EACH OFFICIENCY MOST BE PRECEDED BY FULL PREFIX (EACH O	DEFICIENCY)	
Resident #116's buttocks with wash cloths and was observed to not wipe the male resident's perineal area or clean around his urinary catheter. Further observation of Resident #116's urinary catheter tubing revealed it was not secured to prevent tension on the tubing.  During an interview on 09/16/15 at 2:20 PM, NA #3 verified Resident #116' did not have his catheter tubing secured in place. NA #3 stated she did not wash Resident #116's front perineal area or clean around his urinary catheter because the urinary catheter had already been cleaned earlier. She stated she was expected to clean the resident's perineal area and around the catheter but was not sure if she could clean his buttocks and then go to the front to clean around the penis and catheter. She indicated she could not recall if Resident #116 ever had his catheter tubing secured in place.  During an interview on 09/16/15 at 2:40 PM, Resident #116 stated he had never had his catheter tubing secured in place. He indicated there were times when the staff had provided incontinent care and had stretched the catheter tubing tight. Resident #116 further stated the staff would not always clean the front perineal area or around the catheter tubing during incontinence care.  During an interview on 09/16/15 at 3:05 PM, the Unit Manager stated she expected all resident's with an indwelling urinary catheter to have the tubing secured and to be cleaned around the urinary catheter during incontinence care.  During an interview on 09/17/15 at 3:25 PM, the physician stated she would have expected		

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	TIPLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		345206	B. WNG		7-		C 9/17/2015
	PROVIDER OR SUPPLIER  NHEALTH AND REHABILI			345 MA	T ADDRESS, CITY, STATE, ZIP CODE ANOR ROAD 5 HILL, NC 28754	1 0	9/1//2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VIE	(X5) COMPLETION DATE
F 323 SS=G	Resident #116 to have secured in place. She had some bleeding no she had no way of knot tubing taut would have resident's bleeding. The expected all residents catheter to be cleaned during incontinence catubing secured in place.  During an interview on Director of Nursing (DC expectation for staff to and clean a resident duwith soap and water. The expected staff to clean catheters and the perin incontinence care. The expected all residents we catheter to have the tub 483.25(h) FREE OF ACHAZARDS/SUPERVISI.  The facility must ensure environment remains as as is possible; and each adequate supervision and prevent accidents.	his catheter tubing indicated Resident #116 ted in his urine and that wing if pulling the catheter caused some of the ephysician stated she with an indwelling urinary around the perineal area are and to have the catheter e.  09/17/15 at 4:20 PM, the DN) stated it was her follow the facility policy uring incontinence care the DON further stated she around the urinary eal area during DON also indicated she with an indwelling urinary bing secured. CCIDENT ON/DEVICES  a that the resident is free of accident hazards in resident receives and assistance devices to and staff interviews the int intervention of	F 32		F323 Disclaimer Clause: Madison Health and Rerequests to have this Paragraphic Correction serve as our allegation of compliant alleged date	lan c r wri	of tten

STATEMENT	OF DEFICIENCIES	(X1) DDOMDED/GLIDDLIED/GLIA			ONID 140. 0930-0391
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345206	B. WNG		С
NAME OF P	ROVIDER OR SUPPLIER			STORET ADDRESS OF A STATE OF THE STATE OF TH	09/17/2015
1				STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD	
MADISON	HEALTH AND REHABIL	ITATION		MARS HILL, NC 28754	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 323	- communication page		F 323	of compliance is Octo	ber 15,
	sampled residents (Refracture.	esident #27), sustaining a		2015. Preparation and	or
	Findings included:			execution of this plan	does not
	Quarterly Minimum Da	n Data set (MDS) dated constitute admission t		to nor	
	08/03/15 revealed Resident #27 was admitted to the facility on 08/07/11 and was severely			the existence of, or sco	ope and
	cognitively impaired. F	ognitively impaired. Resident #27 was iagnosed with dementia, anxiety disorder,		severity of any of the o	ited
	severe osteoporosis, a	and depression. Resident		deficiencies, or conclu	sions set
	#27 required extensive assistance with bed mobility and dressing with 2 plus person physical			forth in the statement	of
	assistance. Resident #27 was total dependent on staff with transfers, personal hygiene, and bathing		deficiencies. The plan i	is	
	and required 2 plus pe	rson physical assistance.		prepared and executed	d to
	Resident #27's undated	d care plan revealed a		ensure continuing com	
	problem of self-care de required 2 person assis	stance with bed mobility		with Federal and state	
	and 2 person assistand intentional transfers. Re	ce with mechanical lift for esident #27 had an		regulatory law.	
	osteoporosis and requi	risk for falls with severe red mechanical lift with 2		The Care Plan for resid	ent #27
	person assistance for in	ntentional transfers.		was reviewed and upd	ated by
	Nurse aide care guide t Resident #27 required t	for August 2015 revealed total care with activities of		the Minimum Date Set	(MDS)
	daily living (ADL). Resid	dent #27 required		nurse on August 17, 20	15 upon
	mechanical lift with tran			the residents return fro	om the
	Resident #27's fall risk :	assessment dated ore of 11. A score of 07-18		hospital. The resident	did not
i	ndicated Resident #27	was at high risk for falls.		receive any surgical	
11	ncident report dated 08	3/15/15 revealed Resident		intervention related to	the fall
#	27 had a fall on 08/15/	15 at 11:31 AM with no			
		cumented as minor harm.		Family/RP requested	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	1			ONIB NO. 0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER;	A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345206	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER			ST.	DEET ADDRESS CITY OF ATE THE SOCIETY	09/17/2015
	N HEALTH AND REHABIL	ITATION		348	REET ADDRESS, CITY, STATE, ZIP CODE 5 MANOR ROAD ARS HILL, NC 28754	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 RESERVED TO THE APPROPRIES OF THE PROPRIES OF	BE COMPLETION
F 323	Tom page		F;	323	be kept comfortable.	
	nurse aide (NA) #1 an	adaptive chair assisted by d positioning pad slid from			Nurse Aide # 1 was int	
	adaptive chair onto NA	Resident #27 sliding out of A #1's lap. Resident #27's			and received disciplina	ary
	right leg was in an unu was placed on a backt	usual position. Resident #27			counseling by the Dire	
	stabilized with a pillow	and gait belt onto the			Nursing on August 18,	, 2015
	backboard. On 08/15/15 at 11:51 AM Resident #27 was transported to the emergency room (ER)				regarding resident saf	ety and
via emergency medical transpo		l transport (EMS) for an			importance of following	ng
	Review of a Physician	o order detect COMEME			resident care ploan du	ıring
	revealed, "Send reside	s order dated 08/15/15 ent to ER due to possible			transfers and all activi	ties of
	broken leg."				daily living.	
	Hospital emergency re- revealed (in part) Residuslocated hip and fraction	port dated 08/15/15 dent #27 had right ture of right distal femur.			An audit was conducte September 21, 2015 b	
	Right hip x-ray dated 0 #27 had right hip arthro	8/15/15 revealed Resident			Maria de la carta	
	joint) and femoral comp	onent had become			Director of Nursing an	
	dislocated superiorly. X right knee dated 08/15/				Quality Assurance Coc	
	communicated slightly i	impacted fracture right			of all residents care pl	ans and
	knee with apex anterior	lateral angulation.			transfer status. The au	ıdit
	Nurse's note dated 08/1				included updating all I	Resident
	from bed to chair by NA	ent #27 was transferred #1 and the pad under			Care Information Shee	ets to
	Resident #27 slipped ou slipped to the floor. Res	ut of chair and resident			ensure Nursing Assista	ants have
1 :	sitting in NA #1's lap wit	h legs in strange position.			appropriate information	1
	Resident#27's legs were gait belt onto a backboa	e stabilized with pillow and ard. EMS was summoned				1
Ì	or transport.	Had daminoned			which to provide safe	
1	Nurse's note dated 08/1	5/15 at 8:10 PM (in part)			transfers for all reside	nts. A

STATEMENT	OF DEFICIENCIES	(V4) PROMERENCIES INC.					OMB NO. 0938-0391	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345206	B. WING				C	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09.	/17/2015	
MADISON	N HEALTH AND REHABILI	TATION		345 MANOR ROAD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B	∈ Was	(X5) COMPLETION DATE	
F 323	Continued From page 14			200	implemented on Septe	ember	1	
	revealed Resident #27	arrived back to the facility	F	323	18, 2015 by the Direct	or of		
	at approximately 7:30 Resident #27 was note	PM by EMS via stretcher.  ed to have ace wrap to right			Nursing. The monitori	ng too	I	
	lower extremity.				will be comploeted by	the D	ON	
	Physician's progress n	ote dated 08/18/15			or designated nursing	staff		
	08/15/15 and was sent				member and includes			
	evaluation. Resident #.	27 was found to have right at distal femur fracture.			monitoring of nursing			
	Physician indicated sur	rgery was not performed			assistants performing			
	Resident #27 and fami	sent back to the facility.  ly did not wish to pursue			appropriate transfers	using		
	surgery. Resident #27's	s right hip was #27's right leg had lateral			correct methods and c	_		
	rotation consistent with	dislocation.			mechanical lift devvice			
	On 09/15/15 at 4:30 PM	A an interview was			according to the reside			
	conducted with NA #1 v	who stated she should ical lift on 08/15/15 when			current care plan.	21113		
į.	she transferred Reside	nt #27 out of bed (OOB) ated the nurse aide care			current care plan.			
	guide indicated Resider	nt #27 required a			All residents will conti	nue to	be	
	mechanical lift for trans assistance. NA #1 state	fers with 2 person ed she was in a hurry to			assessed upon admissi	on to		
	get Resident #27 OOB	and rather than use the are guide she transferred			the facility, at the time	of an	v	
	Resident #27 by herself	fusing a gait belt. NA #1			change in status, and c	1	•	
1,	stated she did not ask another NA for assistance with transferring Resident #27 OOB. NA #1 stated					for appropriate transfer status		
1	there were other NA's a	nd staff available for esident #27 but she did			and fall risk care plann			
1	not ask for assistance. I	NA #1 stated she knew			resident care guides w			
(	extremities but decided	ble to bear any weight on to transfer resident by			continue to be updated		20	
1	nerself using a gait belt.	NA #1 stated she had				- 1	- 1	
t	ransferred Resident #2	7 into the chair and the and the cushion and the			Quality Assurance Coo	rdinat	or,	
r	esident slipped out of the	ne chair. NA #1 stated she						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED	
			A. BUILDI	√G				
		345206	B, WNG_			00/	C 17/2015	
NAME OF P	ROVIDER OR SUPPLIER		7	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	1772013	
MADISON	I HEALTH AND REHABIL	TATION	345 MANOR ROAD					
	T							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page	15	F3	23	to reflect appropriate	transf	er	
	held Resident #27 as	resident slid out of the e positioned herself behind		20	need status. Continuir			
	Resident #27 to prote	ct resident's head and				education and inservicing will		
	guided Resident #27's #1's chest. NA #1 stat	head and body onto NA ed Resident #27's			continue to be provided to all			
		room door and called for sical therapist came and			nursing assistants duri	1	1	
supported Resident #27's right leg and Resident #27 was positioned on backboard and vital signs				employee orientation,		,,		
	were taken. NA #1 stated she was counseled by the Director of Nursing (DON) on following the resident's care guide for transfers. NA #1 stated				needed, and during ar			
						200		
	she was reeducated o	n how to use the			nursing staff skills che	cks.		
	required when using th	t 2 person assistance was ne mechanical lift. NA #1			The Resident Care Gui	des an	d	
	stated she was educat fall on how to use the	ed prior to Resident #27's mechanical lift during			Care Plans for all resid	ents w	rill	
		vas hired. NA #1 stated she			continue to be update	d daily	,	
	mechanical lift for trans	sferring Resident #27			as needed, to ensure o	18	- 1	
	because she was in a	nurry.			compliance of the writ	ten pla	an	
1	On 09/15/15 at 4:57 PI				of care.	CO., P.		
	had always required a	who stated Resident #27			or care.			
		assistance and nurse aide						
		echanical lift was required						
		stated the instructions for ft were attached to the lift			TI		1	
	for staff to access.	it were attached to the int			The monitoring tools/a	iudits		
					will continue to be cor	nplete	d	
	On 09/15/15 at 5:30 PM							
		manager who stated NA using the mechanical lift.			by designated nursing		or	
		550 ST PROVING 1			at least ten percent of	total		
	On 09/16/15 at 8:11 AM	STANDARD CONTRACTOR TO THE TANDARD CONTRACTOR			residents weekly for fo	ur		
	conducted with the DOI upon herself to transfer	N who stated NA #1 took it				1		
		t The DON stated NA #1			weeks, then ten perce	nt of		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	E CONSTRUCTION	(X3) DATE SURVEY
		The Committee Control of the Control	A. BUILDING	-	COMPLETED
		345206	B. WNG		C 09/17/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/1//2015
MADISON	N HEALTH AND REHABIL	ITATION	- 1	345 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE
	knew better than to trausing the mechanical worked at the facility for NA #1 was provided displaying Resident #27 DON stated her expect would have followed Rand transferred reside 2 person assistance.  On 09/16/15 at 11:02 A conducted via phone won NA #1 transferred reside using the mechanical lifectived care guide to beginning of shift to incompare the was to be transferred familiar with Resident A provided treatment to reknew resident required transfers. Nurse #1 stated did not ask for assimembers to transfer Reference #1 stated NA #1 should #27's care guide and transfers. On 09/16/15 at 11:46 A was conducted with the stated she was called to after the fall had occurre stated Resident #27's riawkward position and p	ansfer Resident #27 without lift because she had or a long time. DON stated isciplinary action for not a care guide for transfers. It attains were that NA #1 tesident #27's care guide int using mechanical lift with the lift. Nurse #1 who stated dent #27 by herself without lift. Nurse #1 stated NA #1 carry with her at the dicate how Resident #27 Nurse #1 stated NA #1 was #27 because NA #1 esidents on the unit and a mechanical lift for all ted NA #1 was in a hurry listance from other staff esident #27 OOB. Nurse I have followed Resident safely  M a telephone interview weekend Manager who be Resident #27's room ed. Weekend Manager ght leg was in an hysical therapy assessed liger stated Resident #27 oard and right leg was board using a gait belt. ed she received orders	F 323	residents monthly for	tee. The lipresent the hly for

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		ATE SURVEY	
	, dointed total	IDENTIFICATION NUMBER:	A. BUILDIN	G	CC	OMPLETED	
		345206	B. WNG_			С	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/17/2015	
MADISON	LUCALTU AND DELLA DIL	I TANKS A LA		345 MANOR ROAD			
MADISON	HEALTH AND REHABIL	HAHON		MARS HILL, NC 28754			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(44)	
PREFIX TAG	(EACH DEFICIENC' REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From	47					
1 323			F 32	:3			
	Resident #27 was trai	nsported via EMS to the ER.					
	vveekend Manager st	ated NA #1 had transported					
	resident #27 OOB to	the chair by herself without					
	stated NA #1 informer	lift. Weekend Manager J Weekend Manager she					
	had felt comfortable to	transfer resident #27 by					
	herself Weekend Mar	nager stated when NA #1					
	began shift she receiv	ed an assignment and a					
	copy of Resident #27's	s care guide that indicated					
	how resident was to be	e transferred. Weekend					
	Manager stated NA #1	received disciplinary	-2			1 1	
	action by the DON. We	eekend Manager stated					
	after Resident #27 had	d a fall, a list of residents					
	throughout the facility	who required mechanical					
	lift transfer was provide	ed to all NA's and nurses.					
	On 9/16/15 at 12:21 Pi	M an interview was					
		#2 who stated Resident					
	#27's roommate was y						
	Nurse #2 to come into	the room. Nurse #2 stated					
		ng on the floor with NA #1					
	located behind the resi	dent and was holding					
	Resident #27. Nurse #	2 stated Resident #27 had					
	a care guide that indica	ated resident required					
	mechanical lift for all tra	ansfers with 2 person					
1	assistance. Nurse #2 s	tated NA #1 was provided					
[ ]	a copy of Resident #27	's care guide at the					
1	peginning of the shift, N	Nurse #2 stated it was the					
1	be sore guide NA	to follow interventions on					
	accident could have be	#2 stated Resident #27's		1			
1	nave followed care quie	en avoided if NA #1 would de and used mechanical lift		20		1	
1,	vith 2 person assistanc	e for transfer.					
	On 09/16/15 at 2:39 PM	an interview was					
	conducted with NA #3 v	vno stated she was on					
	NA #1 did not ask NA #	7 had a fall. NA #3 stated					
	ransfer Resident #27 C			5			

STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 60	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345206	B. WNG		С
NAME OF I	PROVIDER OR SUPPLIER	040200		OTDGGT LDD TO	09/17/2015
MADISO	N HEALTH AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 345 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E (X5) COMPLETION ATE DATE
	could have assisted N Resident #27 OOB bu NA #3 stated she was sheet at the beginning care guide information assignment sheet. NA indicated if resident wa mechanical lift. NA #3 was required when me transfer. NA #3 stated of mechanical lift wher orientation. NA #3 stated a fall, she received a li facility who required a  On 09/16/15 at 2:52 Pl conducted with NA #4 duty the day Resident stated she brought the equipment to Resident NA #4 stated she had r for assistance to transf #4 stated she was avai transfer of Resident #2 NA #1 for assistance. N received an in-service of using mechanical lift were att stated she received an beginning of shift that ir guide information on ho #4 stated after Residen received a list of all resi required a mechanical I	IA #1 with transferring It was not asked by NA #1. provided an assignment It of shift with the resident's Included on the It is stated the care guide It is stated 2 person assistance It is was educated on use It is was educated on use It is was hired as part of It is was educated on use It is was a part of It is was on was who stated she was on It is was on It is was on It is was on It is was even asked by NA #1 It is was never asked by It is was never	F 32	!3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			T			OMB NO. 0938-0391		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE SURVEY COMPLETED		
		345206	B, WNG				C	
NAME OF	PROVIDER OR SUPPLIER		1 221 Marian		STREET ADDRESS, CITY, STATE, ZIP CODE	09	/17/2015	
MADIDO	MILEAUTI AND DELLE			345 MANOR ROAD				
WADISO	N HEALTH AND REHABIL	ITATION			MARS HILL, NC 28754			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID				(X5)	
PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	Continued From	40			F371			
1 020	F 323 Continued From page 19 On 09/17/15 at 12:11 PM an interview was		F	323	Disclaimer Clause:			
	expectations were that	ministrator who stated her t NA #1 would have			Madison Health and Rehabi	litation		
	followed the facility po	licy for transferring			requests to have this Plan of		tion	
	#27's care guide for tra	uld have followed Resident ansferring resident	120		serve as our written allegati			
	appropriately.				compliance. Our alleged dat	compliance. Our alleged date of		
	On 07/17/15 at 3:20 P				compliance is October 15, 2	015.		
	conducted with the physicism	ysician who stated Resident an stated she had never			Preparation and or executio	n of thi		
	quite gotten the picture	e of how Resident #27's fall			plan does not constitute ad		1	
	had happened. Physic and family did not wan		-	nor agreement with either t				
	with the fractured hip. Physician stated she				existence of, or scope and s		of	
	increased Resident #2 the fracture and Reside			any of the cited deficiencies	, or			
	Physician stated Resid	ent #27 had horrible			conclusions set forth in the	stateme	ent	
	not been moving prior	knees and hips and had to the fall. Physician stated			of deficiencies. The plan is p		d	
	she did not believe Res	sident #27's fall had	-		and executed to ensure con			
F 371	impacted the resident's 483.35(i) FOOD PROC			74	compliance with Federal and	1		
SS=E	STORE/PREPARE/SEI		F3	/ 1	regulatory law.		10/15/15	
	The facility must - (1) Procure food from s	OUICES approved or			Resident Found to be Affe	cted		
	considered satisfactory	by Federal, State or local			The unlabeled frozen bags of	of food	1	
	authorities; and (2) Store, prepare, distr	ibute and serve food			product, including left over	frozen	food	
	under sanitary condition	ns			products, were discarded at		ne of	
					survey by the dietary manag			
		•			residents were found to be	affecte	d	
		*			from the deficient practice.			
	This REQUIREMENT is by:	s not met as evidenced						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI			COMPLETED	
						С	
NAME OF F	PROVIDED OD OURDUIES	345206	B. WING			09/17/2015	
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
MADISON	HEALTH AND REHABIL	ITATION			MANOR ROAD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		WAR	S HILL, NC 28754		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ATE DATE	
E 074	2				Residents Having the Pote	ntial to be	
F 371	Continued From page		F3	71	Affected		
		n and staff interviews the and date 2 of 2 frozen bags			A full incondition of the fur-		
	of food product that we	ere removed from original			A full inspection of the freeze	1 4	
	labeled packaging cor	tainer and failed to have			conducted during the survey,		
•	legible date on 1 of 2 t	pags of left over frozen food			dietary manager, and no othe		
	product that were store	ed in 1 of 1 walk in freezer.			unlabeled items were found.	All dietary	
	The findings included:				staff members were inserviced by the		
	W -				dietary manager on proper la	beling and	
	1. On 09/14/15 at 9:45 AM an initial tour of the kitchen was conducted with the Food Service				storage of frozen food items.		
		tion of the kitchen walk in			-		
	freezer revealed 2 diffe	erent clear sealed plastic			Systemic Change		
	bags of unidentified, un	nlabeled, and undated			A daily monitoring tool was		
1	frozen breaded food pr	oduct that were out of ging container and were					
	available for resident u	se. The Food Service			implemented during survey b	y the	
	Manager stated 1 bag	of the unlabeled and			audits to ensure no further d	eficient	
	unidentifiable frozen br	eaded food product was		1	practice occurs. The dietary n	nanager or	
	fish nuggets.	nd the other was 50 frozen			designated dietary staff mem	ber will	
					conduct daily monitoring of fi	rozen food	
	On 09/14/15 at 2:15 PM				products to ensure proper sto	The state of the s	
1	conducted with the Foo	od Service Manager. The stated the facility did not			labeling of frozen food produ	122	
	have a policy for labelir	ng and dating frozen food			idealing of frezen rood produ		
	that was removed from				Monitoring		
	container.						
	On 09/16/15 at 10:19 A	M an intention was			Findings/audit forms will be p	resented	
		sultant Dietary Manager.			and reviewed during monthly	Quality	
1.	The Consultant Dietary	Manager stated the			Assurance Performance Impro	ovement	
	facility did not have a po				meetings. The food storage an	nd labeling	
	abeling frozen food ren oackaging container. Th				audits will be completed by th		
1	Manager stated he had	written an addendum to			manager or designated dietar	1 2	
t	he facility Food Receivi	ing and Storage policy that			manager of designated dietal	y stail	
	ndicated any food item packaging had to be ide	removed from original entifiable and was required					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		E SURVEY	
	or connection	IDENTIFICATION NUMBER:	A. BUILD	ING_			PLETED	
		345206	B. WING				С	
NAME OF	PROVIDER OR SUPPLIER			0	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/17/2015	
MADIC	ON UEALTH AND DELLARES				45 MANOR ROAD			
MADISC	ON HEALTH AND REHABILI	HATION		MARS HILL, NC 28754				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	-			1	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI: TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
F 37	1 0				daily for four weeks, then w	-	or	
1 37	o o minada i rom pago		F 3	371	four weeks and then month	y. Any		
	to be labeled and dated. The Consultant Dietary Manager stated the 2 different packages of				issues of non-compliance wi	ll be		
	unidentified frozen bre	aded food product in the			corrected immediately durin	ıg audit	s	
	walk in freezer should	have been labeled and			with retraining and/or discip	linary		
	and the Food Service	Dietary Manager stated he Manager educated the			action provided as needed.	The die	tary	
	dietary staff on the nev	v facility policy that items		1	manager will present all find	ings/au	dits	
	original packaging wer	ble and were taken out of e required to be labeled			to the QAPI committee during	ng mon	thly	
	and dated with no exce	eptions.			meeting for six months or ur	ntil		
	kitchen was conducted Manager. Observation freezer revealed 2 bags food in clear zip lock basausage. Further obser of labeled sausage had Food Service Manager of frozen cooked sausa	of the kitchen walk in s of frozen leftover cooked ag that were labeled reation revealed one bag an illegible date. The verified the date on 1 bag age was illegible because			committee deems appropria	te.		
	Manager immediately re sausage from the walk	mudged. The Food Service emoved the illegible dated in freezer. The Food						
	Service Manger stated checked for dated food Thursday, and Friday as	the walk in freezer was on Monday, Tuesday, nd the illegible date on the						
	cooked leftover frozen s	sausage was overlooked.						
	On 09/15/15 at 12:56 Pl conducted with the Food stated his expectations would have noticed durifood dates in the walk in leftover frozen sausage Food Service Managers have removed the cooke illegible date from the walk	M an interview was d Service Manager who were that dietary staff ng scheduled checks of i freezer that cooked had an illegible date. The stated dietary staff should ed sausage with the alk in freezer as part of						
	the procedure for checki	alk in freezer as part of ng outdates and Illegible dated sausage to						

STATEMENT OF DEFICIENCIES (X1) PROVIDER		CVA) DROVADEDIGUES	Transportation of the second	_		OMB V	IO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		345206	B. WNG				С
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09	9/17/2015
MADISO	N HEALTH AND REHABIL	ITATION		34	45 MANOR ROAD 1ARS HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3F	(X5) COMPLETION DATE
F 371	Continued From page him.	22	F3	371	F 520  Disclaimer Clause:		
	who stated the illegibly	nsultant Dietary Manager			Madison Health and Rehabi requests to have this Plan o serve as our written allegati compliance. Our alleged dat	f Correction	ction
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBE QUARTERLY/PLANS	RS/MEET	F 5	20	compliance is October 15, 2  Preparation and or execution	015.	10/15/15 s
	assurance committee of nursing services; a phy facility; and at least 3 of facility's staff.  The quality assessment committee meets at least	t and assurance st quarterly to identify hich quality assessment			plan does not constitute add nor agreement with either to existence of, or scope and so any of the cited deficiencies conclusions set forth in the of deficiencies. The plan is p and executed to ensure con compliance with Federal and	he everity , or statem repare tinuing	of ent d
	develops and implemer action to correct identification to correct identification to correct identification to correct and isclosure of the record except insofar as such a compliance of such correquirements of this section.	nts appropriate plans of ed quality deficiencies.  y may not require so of such committee disclosure is related to the numittee with the stion.  the committee to identify iencies will not be used as			regulatory law.	d State	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	House awareness				SURVEY
							С
		345206	B. WING_			09.	17/2015
	ROVIDER OR SUPPLIER I HEALTH AND REHABIL	ITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  345 MANOR ROAD  MARS HILL, NC 28754				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Œ	(X5) COMPLETION DATE
	Resident that was Affected		and				
F 520	Continued From page	23	F 5	20	Residents having the Poter	ıtial to	be
					Affected		
	Based on observations, review of the facility's Quality Assurance (QA) Program weekly and monthly reviews, and staff interviews the facility failed to maintain implemented monitoring the QA Program had put into place after the August 2014 recertification survey. This was for one recited deficiency which was originally cited in August 2014 and subsequently recited in September 2015 on the current recertification survey. The repeated deficiency was in the area of kitchen sanitation. The continued failure of the facility during two federal surveys of record show a pattern of facility's inability to sustain an effective Quality Assurance Program.  The findings included:  This tag is crossed referred to:  F 371: Food Procurement, Storage, Preparation, and Distribution. Based on observation and staff interviews the facility failed to label and date 2 of 2 frozen bags of food product that were removed from original labeled packaging container and failed to have legible date on 1 of 2 bags of left over frozen food product that were stored in 1 of 1 walk in freezer.				The facility has a Quality Assu Performance Improvement C consisting of the Medical Dire Director of Nursing, Administ at least two other members. Committee meets monthly to existing and newly identified deficiencies.  Systemic  A new QAPI was implemente on September 21, 2015 and for reviewed daily as well as mon QAPI Committee Meeting.	ommittector, rator a The QA o reviev quality d for Fi	nd PI v
					Monitoring	1.1	
	were removed from the and not having a legibl frozen food product sto F 371 was originally cit recertification survey for cleanliness in a pantry	of frozen food product that e original labeled container e date on a bag of left over ored in the walk in freezer. ted during the August 2014 or failure to maintain refrigerator used to store s, sandwiches, and juices			All previous QAPI identified of deficiencies continue to be re the monthly QAPI Committee as indicated based upon prev written plan of correction.All	eviewe e Meeti vious	ng

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/25/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 345206 B. WNG

09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 345 MANOR ROAD MADISON HEALTH AND REHABILITATION MARS HILL, NC 28754 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) action will be completed on or before F 520 Continued From page 24 October 15, 2015. F 520 During an interview on 09/17/15 at 6:31 PM the QA nurse stated the dietary refrigerator and freezer had been monitored for proper labeling and dating of food items during the facility's monthly QA reviews. However, there were no Quality Assurance (QA) Program weekly and monthly reviews for monitoring of the dietary refrigerator and freezer for August 2015 and September 2015.