STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		2/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/13/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 1	E 039		

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 2	E 039		

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]

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	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 3 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 4	E 039		

test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 5 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document a complete analysis of the facility's response to events which activated the facility's emergency preparedness (EP) plan for 2 of 2 emergency events reviewed. The findings included: 1. A review of the facility's EP Plan revealed the plan was activated on 07/18/19, when a "person of interest" in a crime was observed on facility property. The documented analysis on the report for this emergency event revealed it only specified, "Staff responded accordingly." An interview was conducted with the Administrator on 01/24/20 at 1:24 PM. The Administrator stated on 07/18/19 the facility activated its EP plan when a "person of interest" in a crime was observed on the facility's property. The Administrator stated after this emergency event the only documented analysis was that the staff responded accordingly as noted on the	E 039	Facility will complete emergency preparedness exercises to ensure all residents are safe in the event of emergency. All residents of facility have been identified to be at risk based on the content of the regulation as it relates to emergency preparedness. Facility Administrator will attend emergency preparedness training on February 17th. Upon receiving training, Administrator will provide training to all facility staff in all departments on emergency preparedness policies and procedures on February 19th. On February 17th, the Maintenance Director and Administrator received training on apply the After Action Report to the tabletop exercise. The Administrator/Maintenance Director will be	

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	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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E 039	Continued From page 7 event's report. 2. A review of the facility's EP Plan revealed the plan was activated on 10/16/19, when the facility experienced a power outage. The documented analysis on the report for this emergency event revealed, "Staff responded correctly. There were some ground prongs from 3 prong plugs in the red generator outlets that prevented immediate plug in but they were removed and we had access. Outlets are monitored for ground prongs". An interview was conducted with the Administrator on 01/24/20 at 1:24 PM. The Administrator stated on 10/16/19 the facility activated its EP plan when they had a power outage. The Administrator stated after this power outage the only documented analysis was what was noted on the report which included staff responded correctly.	E 039	responsible for utilizing an After Action Report after future training exercises to analyze strengths, areas of improvement, recommendations and conclusions & next steps. Administrator will report analysis of the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan as needed to IDT during QAPI for review. IDT will also review for any additional training or analysis needed. Administrator will report to IDT all future EP events and analysis as they occur. Corrective action will be completed by February 21, 2020.	
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted 01/20/20 through 01/24/20. 5 allegations were investigated and all 5 were unsubstantiated. Event ID #J8UB11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		2/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 8 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to develop a comprehensive care plan for risk for skin tears (Resident #76) for 1 of 2 residents reviewed for skin condition.	F 656	On 1/24/20, MDS reviewed resident #76 care plan and updated care plan to address skin issues. MDS audited all care plans for residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 9 Findings included: Resident #76 was admitted to the facility 04/18/17 with diagnoses including heart failure and thyroid disorder. Resident #76's Physician orders revealed an order dated 05/24/19 for skin sleeves (sleeves that go on the arms to help protect skin from damage) to be worn daily. Review of skin integrity events revealed Resident #76 received a skin tear to her left calf on 05/03/19, received a skin tear to her left upper arm on 08/29/19, received a skin tear to left upper arm 01/17/20, and received a skin tear to her right lower extremity 01/19/20. Review of Resident #76's significant change Minimum Data Set (MDS) dated 01/05/20 revealed Resident #76 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, and dressing. Review of Resident #76's care plan last updated 01/21/20 revealed no care plan to address being at risk for skin tears. An observation of Resident #67 on 01/22/20 at 1:19 PM revealed she had the skin sleeves on both arms as ordered by the Physician. An interview with the MDS Coordinator on 01/24/20 at 8:47 AM revealed she was not the MDS Coordinator in May 2019 but when the care plan was last reviewed after the Physician's order on 05/24/19 for skin sleeves a care plan for fragile skin should have been developed at that	F 656	who have fragile skin. Regional MDS Nurse will In-service MDS nurses on skin risk care plans on 2/18/20. All skin related care plans were audited by Regional MDS Nurse by 1/24/20. DON will review nursing notes and incident reports during clinical meeting daily Monday – Friday for residents with skin tears or skin related issues. DON will update MDS nurse of any potential issues or risk as related to needed care plan. MDS nurse will update care plan as needed. DON will review all skin care plans related to skin issues during clinical meeting daily Monday – Friday for one month then weekly for three months. During QAPI, DON will report findings on results of missed care plans for residents with skin tears to IDT monthly for 6 months then quarterly thereafter. IDT will review findings and make any necessary changes as needed. Corrective action will be completed by February 21, 2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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F 656	Continued From page 10 time. An interview with the Director of Nursing (DON) on 01/24/20 at 12:26 PM revealed Resident #76 should have had a care plan for fragile skin developed the next time her care plan was reviewed after the 05/24/19 Physician's order for skin tears. She stated the reason a care plan was not developed for fragile skin was because it just got missed. An interview with the Administrator on 01/24/20 at 1:27 PM revealed she expected a care plan to have been in place for skin issues for Resident #76.	F 656		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of	F 801		2/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MADISON HEALTH AND REHABILITATION	345 MANOR ROAD MARS HILL, NC 28754

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F 801	Continued From page 11	F 801		

a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food

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	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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F 801	Continued From page 12 service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to employ a Certified Dietary Manager with the competencies and skills required to carry out the food and nutrition services from 1/20/20 to 1/24/20 for 92 of 92 residents who resided in the facility. The findings included: Upon initial entry into the Kitchen on 1/21/20 at 9:30 AM, the Assistant Dietary Manager (ADM) was interviewed. The ADM stated that the facility was without a Certified Dietary Manager (CDM) since 1/20/20 and he indicated he was not a CDM. On 1/24/20 at 11:19 AM an interview with the facility's interim Dietary Manager revealed that she was brought in from another facility on 1/20/20 and would oversee the food and nutrition services at the facility until the newly hired replacement manager arrived to take over these duties. She stated she was a Licensed Practical Nurse and not a Certified Dietary Manager but had worked in the food and nutrition services for several years.	F 801	Facility has hired a Dietary Manager who is enrolled in CDM certification course. All residents in facility are at risk as related to the regulation based on regulation requirements. The Dietary Manager has been hired as of February 3, 2020. Facility registered the new Dietary Manager as of 1/24/20. Administrator will monitor Dietary Managers progress weekly. Dietician Consultant has agreed to precept the new Dietary Manger during the duration of course. Administrator will report progress of Dietary Manger to IDT during QAPI. IDT will make any needed suggestions. IDT will review monthly for 6 months. Corrective action will be completed by February 21, 2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 01/24/2020

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F 801	Continued From page 13	F 801		

An interview was conducted on 1/23/20 at 10:15 AM with the facility's Consultant Registered Dietician (RD) who stated that she was in charge of the clinical oversight of residents. She specified she began her contract with the facility on 12/23/19. The RD stated the facility had not notified her that they did not have a Certified Dietary Manager on staff. She stated that she was available by phone for consultation services and would be available to come to the facility when needed. The consultant RD stated she tried to get into the facility every 10 days to evaluate residents but did not have a set schedule.

A review of the consultant RD's contract with the facility revealed the RD was to be at the facility 12 to 18 hours per month and would provide nutrition assessment, risk management, nutrition intervention, oversight for clinical care, menu and therapeutic diet overview and monitoring, sanitation review, staffing education, state survey readiness, and other duties as mutually agreed upon.

On 1/24/20 at 1:22 PM an interview with the Administrator revealed that the facility's former full-time Certified Dietary Manager quit on 1/19/20 and the facility had been without a CDM since 01/20/20. The Administrator explained that on 1/20/20 she spoke with and had a signed agreement for a new employee who would serve as the facility's Dietary Manager. When asked if the new employee would come into this role with his certification, she indicated he was not a certified dietary manager, but the facility paid for his upcoming training to become certified. The Administrator stated she thought the Interim Dietary Manager would be "grandfathered" into

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F 801	Continued From page 14 the position to oversee the dietary services, even though she was not a CDM, since she had worked in the food and nutrition services for so many years. However, she said she was aware that the position required a Dietary Manager that was certified.	F 801		