DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AMENDED

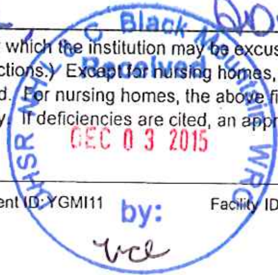
PRINTED: 11/25/2015
FORM APPROVED
OMB NO. 0938-0391

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 09/17/2015

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
F 000	INITIAL COMMENTS 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 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow care plan guide intervention of mechanical lift transfer which resulted in 1 of 6 sampled residents (Resident #27), sustaining a fracture. Findings included: The quarterly Minimum Data set (MDS) dated 08/03/15 revealed Resident #27 was admitted to the facility on 08/07/11 and was severely cognitively impaired. Resident #27 was diagnosed with dementia, anxiety disorder, severe osteoporosis, and depression. Resident #27 required extensive assistance with bed mobility and dressing with 2 plus person physical assistance. Resident #27 was totally dependent on staff with transfers, personal hygiene, and bathing and required 2 plus person physical assistance.	F 282	F282 Disclaimer Clause: Madison Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is October 15, 2015. Preparation and or execution of this plan does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is	10/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra A Gugentanner	Administrator	10/13/2015



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 Resident #27's care plan revealed a problem of self-care deficit. Resident #27 required 2 person assistance with bed mobility and 2 person assistance with mechanical lift for intentional transfers. Resident #27 had an identified problem of at risk for falls with severe osteoporosis and required mechanical lift with 2 person assistance for intentional transfers. The nurse aide care guide for August 2015 revealed Resident #27 required total care with activities of daily living. Resident #27 required mechanical lift with transfers. The incident report dated 08/15/15 revealed Resident #27 had a fall on 08/15/15 at 11:31 AM with no head injury and was documented as minor harm. Narrative incident note revealed Resident #27 was transferred to adaptive chair assisted by nurse aide (NA) #1 and positioning pad slid from chair which resulted in Resident #27 sliding out of adaptive chair onto NA #1's lap. Resident #27's right leg was in an unusual position. Resident #27 was placed on a backboard and legs were stabilized with a pillow and gait belt onto the backboard. On 08/15/15 at 11:51 AM Resident #27 was transported to the emergency room (ER) via emergency medical transport (EMS) for an evaluation. The physician's order dated 08/15/15 revealed, "Send resident to ER due to possible broken leg." The hospital emergency report dated 08/15/15 revealed a right dislocated hip and fracture of right distal femur. The nurse's note dated 08/15/15 at 12:05 PM	F 282	prepared and executed to ensure continuing compliance with Federal and State regulatory law. Resident # 27's care plan, care guide and current transfer status was reviewed for accurancy by the Director of Nursing during the survey process. All information was found to be accurate. The nursing assistant educated and inserviced by the Director of Nursing during the survey process, on following care plans and care guides during resident transfers. An audit was completed by the	

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F 282	Continued From page 2 revealed Resident #27 was transferred from bed to chair by NA #1 and the pad under Resident #27 slipped out of chair and resident slipped to the floor. Resident #27 was found sitting in NA #1's lap with legs in strange position. Resident #27's legs were stabilized with pillow and gait belt onto a backboard. EMS was summoned for transport. On 09/15/15 at 4:30 PM an interview was conducted with NA #1 who stated she should have used the mechanical lift on 08/15/15 when she tranferred Resident #27 out of bed (OOB) into the chair. NA #1 stated the nurse aide care guide indicated Resident #27 required a mechanical lift for transfers with 2 person assistance. NA #1 stated she was in a hurry to get Resident #27 OOB and rather than use the mechanical lift as per care guide she transferred Resident #27 by herself using a gait belt. NA #1 stated she did not ask another NA for assistance with transferring Resident #27 OOB. NA #1 stated there were other NAs and staff available for assistance to transfer resident #27 but she did not ask for assistance. NA #1 stated she knew Resident #27 was not able to bear any weight on extremities but decided to transfer resident by herself using a gait belt. NA #1 stated she had transferred Resident #27 into the chair and the cushion was in the chair and the cushion and the resident slipped out of the chair. NA #1 stated she 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 #1's chest. On 09/15/15 at 4:57 PM an interview was conducted with NA #2 who stated NAs were	F 282	Quality Assurance Coordinator during the survey process to ensure the continued compliance for all residents requiring the use of a mechanical lift for transfers, according to the most current care plan assessment. The audit also included the review and updating of all Resident Care Guides. A daily monitoring tool was implemented on September 18, 2015 by the Director of Nursing. The monitoring tool will be completed by the DON or designated nursing staff member and includes updated by the Quality monitoring of nursing assistants performing appropriate transfers using	

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F 282	Continued From page 3 required to pick up a copy of the resident care guide every day at the beginning of the shift which was included on the NA assignment sheet. NA #2 stated a more detailed individualized resident care guide for NAs that was created from the MDS was placed on a clip board at each nurse's station for the NAs to follow in addition to care guide interventions located on NA assignment sheet. NA #2 stated Resident #27 had always required a mechanical lift for all transfers with 2 person assistance and nurse aide care guide indicated mechanical lift was required for all transfers. On 09/16/15 at 8:11 AM an interview was conducted with the DON who stated NA #1 took it upon herself to transfer Resident #27 without using the mechanical lift. The DON stated NA#1 knew better than to transfer Resident #27 without using the mechanical lift because she had worked at the facility for a long time. DON stated NA #1 was provided disciplinary action for not following Resident #27's care guide for transfers. DON stated her expectations were that NA #1 would have followed Resident #27's care guide and transferred resident using mechanical lift with 2 person assistance. On 09/16/15 at 11:02 AM an interview was conducted via phone with Nurse #1 who stated NA #1 transferred resident #27 by herself without using the mechanical lift. Nurse #1 stated NA #1 received care guide to carry with her at the beginning of shift to indicate how Resident #27 was to be transferred. Nurse #1 stated NA #1 was in a hurry and did not ask for assistance from other staff members to transfer Resident #27 OOB. Nurse #1 stated NA #1 should have followed Resident #27's care guide and	F 282	correct methods and or mechanical lift devices according to the residents' current care plan. All residents will continue to be assessed upon admission to the facility, at the time of any change in status and quarterly, for appropriate transfer status and fall risk care planning. All resident care guides will continue to be updated by the Quality Assurance Coordinator, to reflect appropriate transfer need status. Continuing education and inservicing will continue to be provided to all nursing assistants during new employee orientation, as needed, and during annual nursing staff skills checks. The Resident Care Guides and	

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F 282	Continued From page 4 transferred resident safely and appropriately. On 09/16/15 at 11:46 AM a telephone interview was conducted with the Weekend Manager who stated she was called to Resident #27's room after the fall had occurred. Weekend Manager stated Resident #27's right leg was in an awkward position and physical therapy assessed the leg. Weekend Manager stated Resident #27 was placed on a backboard and right leg was immobilized to the backboard using a gait belt. Weekend Manager stated she received orders from the physician to send Resident #27 to the ER for an evaluation. Weekend Manager stated NA #1 had transported Resident #27 OOB to the chair by herself without using the mechanical lift. Weekend Manager stated NA #1 informed Weekend Manager she had felt comfortable to transfer Resident #27 by herself. Weekend Manager stated when NA #1 began shift she received an assignment and a copy of Resident #27's care guide that indicated how resident was to be transferred. On 9/16/15 at 12:21 PM an interview was conducted with Nurse #2 who stated Resident #27's roommate was yelling for help and told Nurse #2 to come into the room. Nurse #2 stated Resident #27 was sitting on the floor with NA #1 located behind the resident and was holding Resident #27. Nurse #2 stated Resident #27 had a care guide that indicated resident required mechanical lift for all transfers with 2 person assistance. Nurse #2 stated NA #1 was provided a copy of Resident #27's care guide at the beginning of the shift. Nurse #2 stated it was the responsibility of the NA to follow interventions on the care guide. Nurse #2 stated Resident #27's accident could have been avoided if NA #1 would	F 282	Care Plans for all residents will continue to be updated daily, as needed, to ensure continued compliance of the written plan of care. The monitoring tools/audits will continue to be completed by designated nursing staff, for at least ten percent of total residents weekly for four weeks, then ten percent of residents monthly for three months. The Director of Nursing will present results of the audits to the Quality Assurance Performance Improvement committee, monthly for review and recommendations.	

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F 282	Continued From page 5 have followed care guide and used mechanical lift with 2 person assistance for transfer. On 09/16/15 at 2:39 PM an interview was conducted with NA #3 who stated she was on duty when Resident #27 had a fall. NA #3 stated NA #1 did not ask NA #3 for assistance to transfer Resident #27 OOB. NA #3 stated she could have assisted NA #1 with transferring Resident #27 OOB but was not asked by NA #1. NA #3 stated she was provided an assignment sheet at the beginning of shift with the resident's care guide information included on the assignment sheet. NA #3 stated the care guide indicated if resident was to be transferred using a mechanical lift. On 09/16/15 at 2:52 PM an interview was conducted with NA #4 who stated she was on duty the day Resident #27 had a fall. NA #4 stated she brought the backboard and vital sign equipment to Resident #27's room after the fall. NA #4 stated she had not been asked by NA #1 for assistance to transfer Resident #27 OOB. NA #4 stated she was available to assist NA #1 with transfer of Resident #27 but was never asked by NA #1 for assistance. NA #4 stated she received an assignment sheet at the beginning of shift that included resident care guide information on how to transfer resident. On 09/17/15 at 12:11 PM an interview was conducted with the Administrator who stated her expectations were that NA #1 would have followed the facility policy for transferring Resident #27 and would have followed Resident #27's care guide for transferring resident appropriately.	F 282		

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F 315	Continued From page 6	F 315	~~F315~~	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and physician interviews, the facility failed to secure an indwelling urinary catheter tubing and failed to provide catheter care for 2 of 2 residents reviewed for incontinence care (Residents #77 and #116). The findings included: 1) Resident #77 was re-admitted to the facility on 04/16/13 with diagnoses which included multiple joint contractures, muscle weakness, diabetes mellitus, kidney failure, and urinary obstruction, history of urinary tract infections, and indwelling urinary catheter. A review of the most recent Minimum Data Set (MDS) dated 08/31/15 indicated Resident #77 was severely cognitively impaired. The MDS also indicated Resident #77 was totally dependent on staff for activities of daily living (ADLs), had an indwelling urinary catheter and was incontinent of bowel.	F 315	Disclaimer Clause: Madison Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is October 15, 2015. Preparation and or execution of this plan does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and executed to ensure continuing compliance with Federal and State regulatory law. **Resident Found to be Affected and Residents Having the Potential to be Affected** All residents with an indwelling urinary catheter were identified by the Nurse Manager, during the survey process, to ensure catheter tubing was secured and catheter care was provided appropriately to prevent urinary tract	10/15/15

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F 315	Continued From page 7 A review of a care plan dated 06/19/13 indicated Resident #77 had an indwelling urinary catheter related to neurogenic bladder (lack of bladder control) and had the potential for urinary tract infections. The goal specified Resident #77 would remain free of signs and symptoms of urinary tract infection. The approaches included to monitor catheter tubing for kinks or twists in tubing, catheter care every shift, and perineal care after each incontinent episode. During an observation on 09/16/15 at 9:40 AM, Nurse Aide (NA) #3 and Nurse #5 provided incontinence care to Resident #77. The sheet covering Resident #77 was removed and the resident was lying on a protective pad with an indwelling urinary catheter in place. Resident #77 was turned to his right side and had a moderate amount of soft brown stool. NA #3 wiped the resident's buttocks with wash cloths that appeared to be wet then turned him on his left side at which time Resident #77 was observed to have another moderate amount of soft brown stool. NA #3 was observed to place the urinary catheter tubing across the resident's heel protective cushion at the foot of the bed which caused the catheter tubing to become taut (stretched) with no slack in the catheter tubing. NA #3 was observed to wipe Resident #77's buttocks with wash cloths that appeared to be wet and was observed as to not wipe the male resident's perineal area or clean around his urinary catheter. Further observation of Resident #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 tubing secured in place. NA #3 stated she did not	F 315	infections and to restore as much normal bladder function as possible. During the survey process, Resident #77 and #116 were assessed by the Nurse Manager and the Regional Director of Clinical Services (RDCS) to ensure appropriate indwelling urinary catheter placement and securing devices were indeed in place. Education and inservicing for Nurse #5 and Nurse Aide #3 was provided by the Director of Nursing and the RDCS on September 17, 2015 . The education and inservicing included the use of appropriate securing devices for indwelling urinary catheters and incontinent care for residents' with said catheters to ensure the prevention of urinary tract infections and to restore as much normal bladder function as possible. **Systemic Change** Nurse #5 and Nurse Aide #3 identified the need for alternative securing devices for some residents, as the current device (Cath-secure) does not always remain in place appropriately on	

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F 315	Continued From page 8 wash Resident #77's front perineal area or clean around his urinary catheter because the urinary catheter had already been cleaned earlier that morning. She explained she knew she should have cleaned his front perineal area and around the catheter but she was not sure if she could clean his buttocks and then go to the front to clean around the penis and catheter. During an interview on 09/16/15 at 10:50 AM, Nurse #5 stated Resident #77 had never had his catheter tubing secured to prevent tension on the tubing and she was unaware of what should be used to secure the catheter tubing since they did not use tape. Nurse #5 further stated she would have expected the catheter tubing to have been secured. 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 expected all residents with an indwelling urinary catheter to be cleaned around the perineal area during incontinence care and to have the catheter tubing secured in place. During an interview on 09/17/15 at 4:20 PM, the Director of Nursing (DON) stated it was her expectation for staff to follow the facility policy and clean a resident during incontinence care with soap and water. The DON further stated she expected staff to clean around the urinary catheters and the perineal area during incontinence care. The DON also indicated she expected all residents with an indwelling urinary	F 315	various residents. An alternative catheter securing device was made available and implemented on September 18, 2015, (cloth-like catheter leg band). Inservicing for appropriate indwelling urinary catheter care, and the use of catheter securing devices was provided by the Director of Nursing, to all nursing staff members on October 13,2015. A catheter monitoring tool was implemented by the Director of Nursing on September 18, 2015, to ensure ongoing compliance of, all residents with indwelling urinary catheters will receive treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All residents who were identified to have an indwelling urinary catheter received a physician's order to ensure placement of appropriate catheter securing device two times each eight hour shift on September 24, 2015. The said orders were placed on the idenified residents' Medication Administration Records. The Director of Nursing or designated nursing staff member will monitor the	

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F 315	Continued From page 9 catheter to have the tubing secured. 2) Resident #116 was admitted to the facility on 03/30/15 with diagnoses which included Parkinson's disease, urinary retention, pressure ulcers, and urinary tract infection. A review of the most recent Minimum Data Set (MDS) dated 09/01/15 indicated Resident #116 was cognitively intact and was capable of making his needs known. The MDS also indicated Resident #116 required extensive assistance by staff for bed mobility and was totally dependent on staff for all other activities of daily living (ADLs). The MDS also revealed Resident #116 was incontinent of bowel and had an indwelling urinary catheter. A review of a care plan dated 04/13/15 Resident #116 had the potential for urinary tract infections and the goal was to remain free of urinary tract infections. The approaches included to secure the catheter tubing to prevent pulling or tension, to monitor the tubing for kinks or twists, to straighten the tubing as needed to ensure proper drainage, and provide catheter care every shift. During an observation on 09/16/15 at 1:50 PM, Nurse Aide (NA) #3 and Nurse #5 provided incontinence care to Resident #116. The sheet covering Resident #116 was removed and the resident was lying on a protective pad with an indwelling urinary catheter in place. Resident #116 was turned to his right side and had a small amount of brown stool. NA #3 wiped the resident's buttocks with wash cloths that appeared to be wet then turned him on his left side at which time caused the catheter tubing to become taut (stretched) with no slack in the catheter tubing. NA #3 was observed to wipe	F 315	MAR's for appropriate documentation using the catheter monitoring tool. **Monitoring** All residents will continue to receive assessments for incontinence and indwelling urinary catheters, upon admission, quarterly and as needed with any change in condition, to ensure appropriate treatment and services are provided. Continued monitoring of all residents' with an indwelling urinary catheter will be provided by the Director of Nursing or designated nursing staff member. All catheter related monitoring tools will continue daily for two weeks, then weekly for four weeks, then monthly until further notice. The Director of Nursing will maintain and present all findings to the Quality Assurance Performance Improvement committee during the monthly QAPI meetings for review recommendations for continued compliance.	

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F 315	Continued From page 10	F 315		

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

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F 315	Continued From page 11 Resident #116 to have his catheter tubing secured in place. She indicated Resident #116 had some bleeding noted in his urine and that she had no way of knowing if pulling the catheter tubing taut would have caused some of the resident's bleeding. The physician stated she expected all residents with an indwelling urinary catheter to be cleaned around the perineal area during incontinence care and to have the catheter tubing secured in place. During an interview on 09/17/15 at 4:20 PM, the Director of Nursing (DON) stated it was her expectation for staff to follow the facility policy and clean a resident during incontinence care with soap and water. The DON further stated she expected staff to clean around the urinary catheters and the perineal area during incontinence care. The DON also indicated she expected all residents with an indwelling urinary catheter to have the tubing secured.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement intervention of mechanical lift transfer which resulted in 1 of 6	F 323	F323 Disclaimer Clause: Madison Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date	10/15/15

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F 323	Continued From page 12 sampled residents (Resident #27), sustaining a fracture. Findings included: Quarterly Minimum Data set (MDS) dated 08/03/15 revealed Resident #27 was admitted to the facility on 08/07/11 and was severely cognitively impaired. Resident #27 was diagnosed with dementia, anxiety disorder, severe osteoporosis, and depression. Resident #27 required extensive assistance with bed mobility and dressing with 2 plus person physical assistance. Resident #27 was total dependent on staff with transfers, personal hygiene, and bathing and required 2 plus person physical assistance. Resident #27's undated care plan revealed a problem of self-care deficit. Resident #27 required 2 person assistance with bed mobility and 2 person assistance with mechanical lift for intentional transfers. Resident #27 had an identified problem of at risk for falls with severe osteoporosis and required mechanical lift with 2 person assistance for intentional transfers. Nurse aide care guide for August 2015 revealed Resident #27 required total care with activities of daily living (ADL). Resident #27 required mechanical lift with transfers. Resident #27's fall risk assessment dated 08/03/15 revealed a score of 11. A score of 07-18 indicated Resident #27 was at high risk for falls. Incident report dated 08/15/15 revealed Resident #27 had a fall on 08/15/15 at 11:31 AM with no head injury and was documented as minor harm. Narrative incident note (in part) revealed Resident	F 323	of compliance is October 15, 2015. Preparation and or execution of this plan does not constitute admission to nor the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and executed to ensure continuing compliance with Federal and state regulatory law. The Care Plan for resident #27 was reviewed and updated by the Minimum Date Set (MDS) nurse on August 17, 2015 upon the residents return from the hospital. The resident did not receive any surgical intervention related to the fall. Family/RP requested	

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F 323	Continued From page 13 #27 was transferred to adaptive chair assisted by nurse aide (NA) #1 and positioning pad slid from chair which resulted in Resident #27 sliding out of adaptive chair onto NA #1's lap. Resident #27's right leg was in an unusual position. Resident #27 was placed on a backboard and legs were stabilized with a pillow and gait belt onto the backboard. On 08/15/15 at 11:51 AM Resident #27 was transported to the emergency room (ER) via emergency medical transport (EMS) for an evaluation. Review of a Physician's order dated 08/15/15 revealed, "Send resident to ER due to possible broken leg." Hospital emergency report dated 08/15/15 revealed (in part) Resident #27 had right dislocated hip and fracture of right distal femur. Right hip x-ray dated 08/15/15 revealed Resident #27 had right hip arthroplasty (reforming of a joint) and femoral component had become dislocated superiorly. X-ray of Resident #27's right knee dated 08/15/15 revealed communicated slightly impacted fracture right knee with apex anterior lateral angulation. Nurse's note dated 08/15/15 at 12:05 PM revealed (in part) Resident #27 was transferred from bed to chair by NA #1 and the pad under Resident #27 slipped out of chair and resident slipped to the floor. Resident #27 was found sitting in NA #1's lap with legs in strange position. Resident#27's legs were stabilized with pillow and gait belt onto a backboard. EMS was summoned for transport. Nurse's note dated 08/15/15 at 8:10 PM (in part)	F 323	for the resident to continue to be kept comfortable. Nurse Aide # 1 was interviewed and received disciplinary counseling by the Director of Nursing on August 18,, 2015 regarding resident safety and importance of following resident care ploan during transfers and all activities of daily living. An audit was conducted on September 21, 2015 by the Director of Nursing and the Quality Assurance Coordinator, of all residents care plans and transfer status. The audit included updating all Resident Care Information Sheets to ensure Nursing Assistants have appropriate information in which to provide safe care and transfers for all residents. A	

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F 323	Continued From page 14 revealed Resident #27 arrived back to the facility at approximately 7:30 PM by EMS via stretcher. Resident #27 was noted to have ace wrap to right lower extremity. Physician's progress note dated 08/18/15 revealed (in part) Resident #27 sustained a fall on 08/15/15 and was sent to the ER for an evaluation. Resident #27 was found to have right hip dislocation and right distal femur fracture. Physician indicated surgery was not performed and Resident #27 was sent back to the facility. Resident #27 and family did not wish to pursue surgery. Resident #27's right hip was immobilized. Resident #27's right leg had lateral rotation consistent with dislocation. On 09/15/15 at 4:30 PM an interview was conducted with NA #1 who stated she should have used the mechanical lift on 08/15/15 when she transferred Resident #27 out of bed (OOB) into the chair. NA #1 stated the nurse aide care guide indicated Resident #27 required a mechanical lift for transfers with 2 person assistance. NA #1 stated she was in a hurry to get Resident #27 OOB and rather than use the mechanical lift as per care guide she transferred Resident #27 by herself using a gait belt. NA #1 stated she did not ask another NA for assistance with transferring Resident #27 OOB. NA #1 stated there were other NA's and staff available for assistance to transfer Resident #27 but she did not ask for assistance. NA #1 stated she knew Resident #27 was not able to bear any weight on extremities but decided to transfer resident by herself using a gait belt. NA #1 stated she had transferred Resident #27 into the chair and the cushion was in the chair and the cushion and the resident slipped out of the chair. NA #1 stated she	F 323	daily monitoring tool was implemented on September 18, 2015 by the Director of Nursing. The monitoring tool will be comploeted by the DON or designated nursing staff member and includes monitoring of nursing assistants performing appropriate transfers using correct methods and or mechanical lift devvices according to the residents' current care plan. All residents will continue to be assessed upon admission to the facility, at the time of any change in status, and quarterly, for appropriate transfer status and fall risk care planning. All resident care guides will continue to be updated by the Quality Assurance Coordinator,	

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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 #1's chest. NA #1 stated Resident #27's roommate opened the room door and called for help. NA #1 stated physical therapist came and supported Resident #27's right leg and Resident #27 was positioned on backboard and vital signs 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 she was reeducated on how to use the mechanical lift and that 2 person assistance was required when using the mechanical lift. NA #1 stated she was educated prior to Resident #27's fall on how to use the mechanical lift during orientation when she was hired. NA #1 stated she used bad judgment and did not use the mechanical lift for transferring Resident #27 because she was in a hurry.

On 09/15/15 at 4:57 PM an interview was conducted with NA #2 who stated Resident #27 had always required a mechanical lift for all transfers with 2 person assistance and nurse aide care guide indicated mechanical lift was required for all transfers. NA #2 stated the instructions for using the mechanical lift were attached to the lift for staff to access.

On 09/15/15 at 5:30 PM an interview was conducted with the unit manager who stated NA #1 was reeducated on using the mechanical lift.

On 09/16/15 at 8:11 AM an interview was conducted with the DON who stated NA #1 took it upon herself to transfer Resident #27 without using the mechanical lift. The DON stated NA #1

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to reflect appropriate transfer need status. Continuing education and inservicing will continue to be provided to all nursing assistants during new employee orientation, as needed, and during annual nursing staff skills checks.

The Resident Care Guides and Care Plans for all residents will continue to be updated daily, as needed, to ensure continued compliance of the written plan of care.

The monitoring tools/audits will continue to be completed by designated nursing staff, for at least ten percent of total residents weekly for four weeks, then ten percent of

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F 323	Continued From page 16 knew better than to transfer Resident #27 without using the mechanical lift because she had worked at the facility for a long time. DON stated NA #1 was provided disciplinary action for not following Resident #27's care guide for transfers. DON stated her expectations were that NA #1 would have followed Resident #27's care guide and transferred resident using mechanical lift with 2 person assistance. On 09/16/15 at 11:02 AM an interview was conducted via phone with Nurse #1 who stated NA #1 transferred resident #27 by herself without using the mechanical lift. Nurse #1 stated NA #1 received care guide to carry with her at the beginning of shift to indicate how Resident #27 was to be transferred. Nurse #1 stated NA #1 was familiar with Resident #27 because NA #1 provided treatment to residents on the unit and knew resident required a mechanical lift for all transfers. Nurse #1 stated NA #1 was in a hurry and did not ask for assistance from other staff members to transfer Resident #27 OOB. Nurse #1 stated NA #1 should have followed Resident #27's care guide and transferred resident safely and appropriately. On 09/16/15 at 11:46 AM a telephone interview was conducted with the Weekend Manager who stated she was called to Resident #27's room after the fall had occurred. Weekend Manager stated Resident #27's right leg was in an awkward position and physical therapy assessed the leg. Weekend Manager stated Resident #27 was placed on a backboard and right leg was immobilized to the backboard using a gait belt. Weekend Manager stated she received orders from the physician to send Resident #27 to the ER for an evaluation. Weekend Manager stated	F 323	residents monthly for three months and continue as directed by the Quality Assurance Performance Improvement committee. The Director of Nursing will present results of the audits to the QAPI committee monthly for review and recommendations.	

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F 323	Continued From page 17 Resident #27 was transported via EMS to the ER. Weekend Manager stated NA #1 had transported Resident #27 OOB to the chair by herself without using the mechanical lift. Weekend Manager stated NA #1 informed Weekend Manager she had felt comfortable to transfer resident #27 by herself. Weekend Manager stated when NA #1 began shift she received an assignment and a copy of Resident #27's care guide that indicated how resident was to be transferred. Weekend Manager stated NA #1 received disciplinary action by the DON. Weekend Manager stated after Resident #27 had a fall, a list of residents throughout the facility who required mechanical lift transfer was provided to all NA's and nurses. On 9/16/15 at 12:21 PM an interview was conducted with Nurse #2 who stated Resident #27's roommate was yelling for help and told Nurse #2 to come into the room. Nurse #2 stated Resident #27 was sitting on the floor with NA #1 located behind the resident and was holding Resident #27. Nurse #2 stated Resident #27 had a care guide that indicated resident required mechanical lift for all transfers with 2 person assistance. Nurse #2 stated NA #1 was provided a copy of Resident #27's care guide at the beginning of the shift. Nurse #2 stated it was the responsibility of the NA to follow interventions on the care guide. Nurse #2 stated Resident #27's accident could have been avoided if NA #1 would have followed care guide and used mechanical lift with 2 person assistance for transfer. On 09/16/15 at 2:39 PM an interview was conducted with NA #3 who stated she was on duty when Resident #27 had a fall. NA #3 stated NA #1 did not ask NA #3 for assistance to transfer Resident #27 OOB. NA #3 stated she	F 323		

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F 323	Continued From page 18	F 323		

could have assisted NA #1 with transferring Resident #27 OOB but was not asked by NA #1. NA #3 stated she was provided an assignment sheet at the beginning of shift with the resident's care guide information included on the assignment sheet. NA #3 stated the care guide indicated if resident was to be transferred using a mechanical lift. NA #3 stated 2 person assistance was required when mechanical lift was used for transfer. NA #3 stated she was educated on use of mechanical lift when she was hired as part of orientation. NA #3 stated after Resident #27 had a fall, she received a list of all residents in the facility who required a mechanical lift for transfer.

On 09/16/15 at 2:52 PM an interview was conducted with NA #4 who stated she was on duty the day Resident #27 had a fall. NA #4 stated she brought the backboard and vital sign equipment to Resident #27's room after the fall. NA #4 stated she had not been asked by NA #1 for assistance to transfer Resident #27 OOB. NA #4 stated she was available to assist NA #1 with transfer of Resident #27 but was never asked by NA #1 for assistance. NA #4 stated she had received an in-service on how to transfer resident using mechanical lift and shared 2 person assistance was required when using mechanical lift. NA #4 stated instructions on how to use the mechanical lift were attached to the lift. NA #4 stated she received an assignment sheet at the beginning of shift that included resident care guide information on how to transfer resident. NA #4 stated after Resident #27 had a fall, she received a list of all residents in the facility who required a mechanical lift for transfer and signed a paper that indicated she knew how to transfer resident using mechanical lift.

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F 323	Continued From page 19 On 09/17/15 at 12:11 PM an interview was conducted with the Administrator who stated her expectations were that NA #1 would have followed the facility policy for transferring Resident #27 and would have followed Resident #27's care guide for transferring resident appropriately. On 07/17/15 at 3:20 PM an interview was conducted with the physician who stated Resident #27 had a fall. Physician stated she had never quite gotten the picture of how Resident #27's fall had happened. Physician stated Resident #27 and family did not want anything fixed surgically with the fractured hip. Physician stated she increased Resident #27's pain medication after the fracture and Resident #27 was not in pain. Physician stated Resident #27 had horrible flexion contractures of knees and hips and had not been moving prior to the fall. Physician stated she did not believe Resident #27's fall had impacted the resident's quality of life.	F 323	F371 Disclaimer Clause: Madison Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is October 15, 2015. Preparation and or execution of this plan does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	**Resident Found to be Affected** The unlabeled frozen bags of food product, including left over frozen food products, were discarded at the time of survey by the dietary manager. No residents were found to be affected from the deficient practice.	10/15/15

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F 371	Continued From page 20 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 findings included: 1. On 09/14/15 at 9:45 AM an initial tour of the kitchen was conducted with the Food Service Manager. An Observation of the kitchen walk in freezer revealed 2 different clear sealed plastic bags of unidentified, unlabeled, and undated frozen breaded food product that were out of original labeled packaging container and were available for resident use. The Food Service Manager stated 1 bag of the unlabeled and unidentifiable frozen breaded food product was 12 frozen crab cakes and the other was 50 frozen fish nuggets. On 09/14/15 at 2:15 PM an interview was conducted with the Food Service Manager. The Food Service Manager stated the facility did not have a policy for labeling and dating frozen food that was removed from original packaging container. On 09/16/15 at 10:19 AM an interview was conducted with the Consultant Dietary Manager. The Consultant Dietary Manager stated the facility did not have a policy for dating and labeling frozen food removed from original packaging container. The Consultant Dietary Manager stated he had written an addendum to the facility Food Receiving and Storage policy that indicated any food item removed from original packaging had to be identifiable and was required	F 371	**Residents Having the Potential to be Affected** A full inspection of the freezer was conducted during the survey, by the dietary manager, and no other unlabeled items were found. All dietary staff members were inserviced by the dietary manager on proper labeling and storage of frozen food items. **Systemic Change** A daily monitoring tool was implemented during survey by the audits to ensure no further deficient practice occurs. The dietary manager or designated dietary staff member will conduct daily monitoring of frozen food products to ensure proper storage and labeling of frozen food products. **Monitoring** Findings/audit forms will be presented and reviewed during monthly Quality Assurance Performance Improvement meetings.The food storage and labeling audits will be completed by the dietary manager or designated dietary staff	

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F 371	Continued From page 21 to be labeled and dated. The Consultant Dietary Manager stated the 2 different packages of unidentified frozen breaded food product in the walk in freezer should have been labeled and dated. The Consultant Dietary Manager stated he and the Food Service Manager educated the dietary staff on the new facility policy that items which were unidentifiable and were taken out of original packaging were required to be labeled and dated with no exceptions. 2. On 09/14/15 at 9:45 AM an initial tour of the kitchen was conducted with the Food Service Manager. Observation of the kitchen walk in freezer revealed 2 bags of frozen leftover cooked food in clear zip lock bag that were labeled sausage. Further observation revealed one bag of labeled sausage had an illegible date. The Food Service Manager verified the date on 1 bag of frozen cooked sausage was illegible because the black writing was smudged. The Food Service Manager immediately removed the illegible dated sausage from the walk in freezer. The Food Service Manger stated the walk in freezer was checked for dated food on Monday, Tuesday, Thursday, and Friday and the illegible date on the cooked leftover frozen sausage was overlooked. On 09/15/15 at 12:56 PM an interview was conducted with the Food Service Manager who stated his expectations were that dietary staff would have noticed during scheduled checks of food dates in the walk in freezer that cooked leftover frozen sausage had an illegible date. The Food Service Manager stated dietary staff should have removed the cooked sausage with the illegible date from the walk in freezer as part of the procedure for checking outdates and personally provided the illegible dated sausage to	F 371	daily for four weeks, then weekly for four weeks and then monthly. Any issues of non-compliance will be corrected immediately during audits with retraining and/or disciplinary action provided as needed. The dietary manager will present all findings/audits to the QAPI committee during monthly meeting for six months or until committee deems appropriate.	

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F 371	Continued From page 22 him. On 09/16/15 at 10:19 AM an interview was conducted with the Consultant Dietary Manager who stated the illegibly dated frozen leftover cooked sausage should have been removed from the walk in freezer and discarded.	F 371	~~F 520~~ Disclaimer Clause: Madison Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is October 15, 2015.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	Preparation and or execution of this plan does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	10/15/15

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 09/17/2015

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 520	Continued From page 23 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 was recited for F 371 for failing to label and date 2 bags of frozen food product that were removed from the original labeled container and not having a legible date on a bag of left over frozen food product stored in the walk in freezer. F 371 was originally cited during the August 2014 recertification survey for failure to maintain cleanliness in a pantry refrigerator used to store nutritional supplements, sandwiches, and juices labeled for resident use.	F 520	**Resident that was Affected and Residents having the Potential to be Affected** The facility has a Quality Assurance Performance Improvement Committee consisting of the Medical Director, Director of Nursing, Administrator and at least two other members.The QAPI Committee meets monthly to review existing and newly identified quality deficiencies. **Systemic** A new QAPI was implemented for F371 on September 21, 2015 and findings reviewed daily as well as monthly in the QAPI Committee Meeting. **Monitoring** All previous QAPI identified quality deficiencies continue to be reviewed in the monthly QAPI Committee Meeting as indicated based upon previous written plan of correction.All corrective	

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F 520	Continued From page 24 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.	F 520	action will be completed on or before October 15, 2015.	