STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 11/20/2020

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 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 11/18/20 with exit from the facility on 11/18/20. Additional information was obtained through 11/20/20, therefore the exit date was changed to 11/20/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# Y9GJ11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 11/18/20 with exit from the facility on 11/18/20. Additional information was obtained through 11/20/20, therefore the exit date was changed to 11/20/20. The facility was found out of compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. A total of 7 allegations were investigated and none were substantiated. Event ID# Y9GJ11.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/18/20

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

Electronically Signed | 12/11/2020

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 11/20/2020

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
F 880	Continued From page 1	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 11/20/2020

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
F 880	Continued From page 2 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the facility's infection control policies, the facility failed to implement the "Madison Health Pandemic Viral Illness, Infection Control Measures" and "Emergency Procedure Pandemic", when staff failed to remove gloves, perform hand hygiene and wear a face covering when they entered and exited resident rooms for 2 of 2 residents reviewed for infection control practices (Resident #1 and #2). These failures occurred during a COVID-19 pandemic. The findings included: A review was completed of a facility's policy titled, "Madison Health Pandemic Viral Illness, Infection Control Measures" (revised 3/30/20) and "Emergency Procedure Pandemic" (revised 3/30/20), where the policy require staff to use face coverings, hand washing or use of an alcohol-based hand sanitizer before entering and after exiting resident rooms.	F 880	On 11/18/20 HK#1 was inserviced on hand hygiene, glove use and face covering requirements. This was completed by the Infection Control Nurse. All staff were inserviced on infection control, including hand hygiene, glove use and face covering. This was completed by the Infection Control Nurse on 11/18/20. Infection Control Nurse immediately completed an audit of the entire building to ensure all employees were wearing masks, glove use and performing hand hygiene. This was completed on 11/18/20. One hundred percent of staff will be inserviced on the video: CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out!. Inservicing will be completed by 12/18/20. This video will be incorporated into general orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 11/20/2020

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
F 880	Continued From page 3 An observation was conducted on 11/18/2020 at 9:35 AM of Housekeeper (HK) #1 in room #210 cleaning the mirror above the sink basin. HK#1, was wearing gloves, but no face covering while Resident #1 was sitting in room #210. HK#1 did not remove her gloves, nor, wash her hands or use the available hand sanitizer after leaving the resident's room. HK#1 then proceeded to enter room #211 where she did not use available hand sanitizer or wash her hands, nor, did she remove her gloves, or wear a face cover before entering Resident #2's room while the resident was in the room. Observations on 11/18/20 at 9:45 AM revealed the unit manager entered room #211 where HK#1 was cleaning the mirror and informed HK#1 that she was required to wear a mask and new gloves when moving from room to room. HK#1 immediately left room #211 without a face covering and no gloves and proceeded down the hallway into the cafeteria where she retrieved a face covering. On 11/18/2020 at 10:00 AM an interview with the Infection Control Nurse revealed the 200 South Hall was identified as a non-COVID-19 hallway. An interview was conducted on 11/18/2020 at 10:30 AM with HK#1 which revealed she had received recent COVID-19 pandemic training and was instructed to wash or sanitize her hands when entering and exiting each resident's room. HK #1 confirmed she forgot her mask after she removed it while in the cafeteria and she did not have a mask on and forgot to remove her gloves and wash her hands or use hand sanitizer between rooms #210 and #211.	F 880	Infection Control Nurse will complete two educations related to COVID-19 precautions twice a week for two months starting 11/18/20 and then as directed by the QAPI team. The QAPI Team performed a root cause analysis regarding tag F880 on 12/1/20. The QAPI Team determined the root cause to be that the housekeeper was a non-nursing employee and could have benefited from reinforcement of awareness and training. The QAPI team has created an Awareness Poster to remind staff to reapply mask and perform hand hygiene when exiting the breakroom as well as throughout the building. These will be implemented by 12/18/20 by the Director of Nursing or designee. Infection Control Nurse, Director of Nursing, Administrator or Weekend Manager will complete a PPE and hand hygiene audit daily using the Infection Control Auditing Tool. Five staff members of varied departments will be audited every day for 2 months. Results will be reviewed by the Administrator and presented to the QAPI team. Further monitoring will occur as directed by the QAPI team. The Regional Clinical Nurse will audit six staff members (clinical and non-clinical) once a week for two months for PPE use, hand hygiene and glove use. Results will be reviewed by the Administrator and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING _____ B. WING _____	C 11/20/2020

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
F 880	Continued From page 4 Interview was conducted on 11/18/2020 at 1:40 PM, with the Infection Control Nurse (ICN), who stated all staff had been educated to perform hand hygiene when entering and exiting a resident's room. ICN confirmed she provided in-servicing and COVID-19 training to all staff, including hand hygiene and wearing a mask and donning and doffing PPE. ICN provided staff signed logs confirming staff received this training. The ICN confirmed staff were to wear mask while in the facility.	F 880	presented to the QAPI team. Further monitoring by the Regional Clinical Nurse will occur as directed by the QAPI Team. The Administrator is responsible for implementation. Date of Compliance will be 12/18/20.	