STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015214	A. BUILDING ______ B. WING ______	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON MANOR NURSING HOME	**3891 SULLIVAN ST MADISON, AL 35758**

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Resident Identifier (RI) #10's Significant Change (SC) Minimum Data Set (MDS) assessment, dated 04/15/19, reflected RI #10 was receiving Hospice Services. This deficient practice affected RI #10 one of 19 sampled residents whose MDS assessments were reviewed. Findings Include: RI #10 was re-admitted to the facility on 01/29/19, with diagnoses including but not limited to Alzheimer's, Dementia, Chronic Obstructive Pulmonary Disease and Acute Respiratory Failure. A review of RI #10's physician orders, dated 03/29/19, revealed Amedisys Hospice was to evaluate and treat, as indicated. A review of RI #10's SC MDS assessment, dated 04/15/19, did not identify RI #10 as having received hospice services during this assessment period. On 07/25/19 at 10:50 a.m., the surveyor conducted an interview with Employee Identifier (EI) #5, Registered Nurse/MDS Coordinator. The surveyor asked EI #5 was she familiar with RI #10. EI #5 said no but she did know RI #10's	F 641	THIS PLAN OF CORRECTION CONSTITUTES A WRITTEN ALLEGATION OF SUBSTANTIAL COMPLIANCE WITH FEDERAL AND MEDICAID REQUIREMENTS, AND STATE REQUIREMENTS WHEN NECESSARY. How the corrective action will be accomplished for those identified residents affected by the deficient practice. The New and Current MDS Coordinator corrected the miscoded Significant Change on 8-7-2019 and Transmitted to CMS on 8-9-2019. How the facility will identify other residents having potential to be affected by the deficient practice. The MDS Coordinator conducted a 100% audit on 8-7-2019 of all Hospice Residents who have had Significant Changes due to admission to Hospice. None were found to be out of compliance by incorrect coding. What Measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. To ensure that this deficient practice does not recur training will begin 8-16-2019 on	8/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/15/2019

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 641	Continued From page 1 name. The surveyor asked EI #5 when was RI #10's hospice ordered. EI #5 said on 3/29/19. The surveyor asked EI #5 how long had RI #10 been receiving hospice services. EI #5 said about four months. The surveyor asked EI #5 was RI #10 coded for hospice services during the SC assessment dated 04/15/19. EI #5 said no. EI #5 was asked should RI #10 have been coded for hospice during the SC assessment period. EI #5 said yes. EI #5 was asked if this was an accurate assessment . EI #5 said probably not, it was not correct for hospice.	F 641	F641 (Accuracy of Assessments)by the Director of Nurses and the Current Certified MDS Coordinator to be completed by 8-29-2019 to all members of the Assessment Team. Members of the Interdisciplinary Team who are not trained by 8-29-2019 will not be allowed to work until training is complete. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. A monitoring tool has been developed to monitor all Hospice Significant Change Assessments weekly for 4 weeks and monthly for 5 months by the MDS Coordinator. The DON/Designee will review all deficient practices found by the monitoring process and provide education and or appropriate discipline. Monitoring will begin 8-22-19. The monitoring tool and Corrective Action if needed will be placed in the Plan of Correction Binder in the Administrators Office.	
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		8/29/19

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F 880	Continued From page 2 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	F 880		

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F 880	Continued From page 3 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, interviews, medical record review and review of facility policies titled, "Hand Hygiene Policy and Procedure" and "Medication Administration Procedures Nasal Inhalers, Sprays, and Pumps", the facility failed to ensure a Licensed Practical Nurse (LPN): 1. changed gloves and washed her hands after assisting Resident Identifier (RI) #31 to blow his/her nose, 2. wiped off the nasal spray bottle prior to recapping the bottle and returning it to the cart, 3. washed her hands before applying gloves to administer RI #31's eye drops after pulling the light cord and privacy curtain with bare hands, and 4. removed gloves used to administer eye drops before adjusting RI #31's bed control and pulling the light cord. This affected RI #31, one of five residents observed during medication pass observations. Findings Include:	F 880	How the corrected action will be accomplished for those identified residents affected by the deficient practice. The Licensed Nurse EI#2 who was observed assisting RI#31 to blow his nose without changing gloves, administer nasal spray and recapping the container without wiping the tip, obtaining eye drops from the medication cart and reentering the patients room pulling light cord and privacy curtain then donning gloves without washing her hands, yet administering eye drops, wearing the same gloves adjusted the bed with the hand control, pulled the light cord and privacy curtain again all with the same gloves has been Counseled and Educated on 8-12-2019. This education included F880,Infection Prevention and Control, Hand Hygiene, Glove Use, and Medication Administration Policies and Procedures for Nasal Inhalers, Sprays,	

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F 880	Continued From page 4 A review of a facility policy titled, "Hand Hygiene Policy and Procedure" with a revised date of 6/17, revealed: "...Procedure: 1. Hand hygiene is a general term that applies to either washing hands with soap and water or the use of an antiseptic hand rub, also known as alcohol-based rub... 3. Perform hand hygiene after contact with...mucous membranes... prior to donning and after gloves are removed, and when otherwise indicated to avoid transfer of microorganisms to other...environments. 4. It may be necessary to perform hand hygiene between tasks and procedures on the same resident to prevent cross contamination..." A review of a facility policy titled, "Medication Administration Procedures Nasal Inhalers, Sprays, and Pumps", with a date of 01/12, revealed: "...Wipe the administration device with a clean tissue and replace the protective cap..." RI #31 was admitted to the facility on 08/23/18, with diagnosis of Hemiplegia Following Cerebral Infarction Affecting Left Nondominant Side. On 07/23/19 at 8:24 a.m., the surveyor observed Employee Identifier (EI) #2, LPN, administer medications to RI #31. The surveyor observed EI #2 assist RI #31 to blow his/her nose and without changing gloves, administer the nasal spray to the resident. EI #2 was observed placing the cap back on the nasal spray without wiping the tip of the bottle off and placing it back into the container. EI #2 obtained eye drops from the medication cart and re-entered RI #31's room and pulled the light cord and the privacy curtain with her bare hands. EI #2 applied her gloves without	F 880	and Pumps to prevent cross contamination. How the Facility will identify other residents having the potential to be affected by the same deficient practice. All other observations performed during the Survey were done correctly per the Facilities Infection Prevention and Control Policies and Procedure and no deficient practices were observed. Mandatory Training will begin 8-13-19 on F880 (Infection, Prevention and Control) to all Licensed Nurses to include Hand Hygiene, Donning and Doffing Gloves, Administration of Nasal Inhalers, Eye Drops, and Sprays. Nurses who have not been trained by 8-29-19 will not be allowed to return to work until training is complete. What measure will be put into place or systemic changes made to ensure deficient practice will not recur. All additional staff, including contracted staff will be trained on F880 Infection Prevention and Control, Hand Hygiene Glove Use Policies and Procedures to prevent cross contamination by the DON, Staff Development Nurse or Designee. Training will begin on 8-13-19 and conclude on 8-29-19. Any staff member not trained by this date will not be allowed to work until training is complete. The same education will be provided as part of the Infection Prevention and Control Training during orientation for all newly hired staff and during Annual Infection Prevention and Control Inservice.	

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F 880	Continued From page 5 washing her hands and administered RI #31's eye drops. While still wearing the same gloves, EI #2 was observed adjusting the bed control, pulling the light cord and the privacy curtain. On 07/25/19 at 12:22 p.m., an interview was conducted with EI #2. EI #2 was asked when should she change gloves and wash her hands during medication pass. EI #2 said at the very beginning and depending on what she was doing. EI #2 said if she touched anything that was considered contaminated or dirty she should change her gloves and wash her hands. EI #2 was asked should she change her gloves after pulling the light cord and privacy curtain. EI #2 replied yes. EI #2 was asked did she change her gloves and wash her hands in RI #31's room after pulling the light cord and privacy curtain, before administering his/her eye drops. EI #2 stated no, she did not. EI #2 was asked did she change her gloves and wash her hands after she held the tissue for RI #31 to blow his/her nose before continuing to administer the nasal spray. EI #2 said no. EI #2 was asked did she clean the tip of the nasal spray before storing it back in the medication cart. EI #2 answered no. EI #2 was asked what was the concern with these issues. EI #2 answered the spread of bacteria, infection control. On 07/25/19 at 12:37 p.m., an interview was conducted with EI #1, Registered Nurse (RN)/Director of Nursing. EI #1 was asked when should nurses wash their hands during med pass. EI #1 said in between each task, in between each room and each patient, and if there were different types of medications such as eye drops, ear drops and those sort of things. EI #1 was asked should nasal spray be wiped off after	F 880	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, ie.,what program will be put into place to monitor the continued effectiveness of the systemic changes. Beginning 8-22-2019, The Staff Development Coordinator/Designee will monitor 1 Licensed Nurse on each shift during Medication Administration/pass weekly X4 weeks then monthly for an additional 5 months on a Monitoring Tool. The DON will review, initial, and follow up on any deficient practice with Education and/or appropriate discipline. The updated and Reviewed Monitoring Tool will be place in the Plan of Correction Binder in the Administrators Office.	

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F 880	Continued From page 6 administration before storing in the cart. EI #1 replied yes. EI #1 was asked should a nurse change her gloves and wash her hands after holding a Kleenex tissue for a resident to blow his/her nose before continuing with nasal spray administration. EI #1 stated yes. EI #1 was asked should a nurse change gloves and wash her hands after pulling a light cord and privacy curtain while wearing gloves and then administering eye drops. EI #1 said yes. EI #1 was asked what was the concern with nurses not changing gloves and washing their hands when contaminated. EI #1 answered passing infection around, bacteria and bugs from one person to another, including staff, visitors and residents; transmission of infection.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of a facility's form titled, "DISHWASHING MACHINE TEMPERATURE LOG" and the "2017 Food Code", the facility failed to ensure the temperature gauge of the dish machine provided accurate readings for wash and rinse temperatures. This had the potential to affect all 72 residents for whom meals were prepared and served at the time of this survey. Findings Include: The "2017 Food and Drug Administration Food	F 908	How the corrective action will be accomplished for those identified residents affected by the deficient practice. The Temperature Gauge that was located in a difficult to see area of the Dish Machine as stated in the Surveyors findings was replaced with a larger easier to read gauge by the Auto Chlor Technician during the Survey on 7-25-2019.The Dishwashing Temperature has been taken and documented from the operating Gauge since installation. A work order to install a brand new updated dishwashing machine was initiated on	8/29/19

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F 908	Continued From page 7 Code" revealed: "...4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature...(B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than... (120 degrees F) (Fahrenheit)..." The data plate affixed to the dish machine specified a minimum water temperature of 125 degrees F. During the initial kitchen tour, on 07/23/19 at 7:50 AM,the surveyor observed the posted "DISHWASHING MACHINE TEMPERATURE LOG" on which staff documented daily wash temperatures of 130 degrees F, daily rinse temperatures of 140 degrees F and a chlorine concentration of 50 parts per million (PPM). Despite the recording of three sets of data (breakfast, lunch and supper) daily for 24 days of July, there was no variation in any of the documentation. On 07/24/19, at 11:45 AM, the surveyor observed the water temperature gauge of the dish machine (located under the dish counter), to be 124 degrees F for the wash water (after two cycles had run) and 124 degrees F for the rinse. The staff member (and surveyor) had to squat down and put their head under the counter to view the gauge. The staff member verified with the surveyor, an adequate chlorine concentration on the surface of a utensil. All temperatures and all chemical concentrations (PPM) were consistently documented the same on 07/24/19, as for every other day. On 07/24/19 at 1:30 PM, during the processing of	F 908	7-25-2019 to be installed 8-15-2015. How the facility will identify other residents having the potential to be affected by the same deficient practice. This deficient practice was written at a level that affected 72 of 72 residents the same measures were taken to immediately correct the deficient practice for all affected residents. The Temperature Gauge was replaced with a larger easier to read gauge on 7-25-2019. The Temperature Log for the dishwashing machine was immediately changed to log the Gauge Thermometer Temperature as opposed to the Probe Thermometers being used at the time of the survey. A work order to replace the dishwashing machine with easy to read gauges was placed on 7-25-2019 and was installed on 8-15-2019. Training has been conducted with all Dietary and Maintenance Staff on properly operating and cleaning the new dish washing machine per manufacturers specifications. The objective of this training was how to properly read the Temperature Gauge on the new Dish machine as well as the Manufacturers recommendations for Temperature of 120 degrees for both wash and rinse and Chlorine Residual 50 PPM minimum. What measure will be put in place or systematic changes made to insure the deficient practice will not recur. Training will begin on 8-21 on the content of F908(Essential Equipment, Safe Operating Condition) and the for all Dietary and Maintenance Staff. The	

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F 908	Continued From page 8 the lunch dishes, the surveyor observed a wash temperature of 98 degrees F and a rinse of 115 degrees F. The next cycle yielded temperatures of 110 degrees F for the wash and 118 degrees F for the rinse. The Certified Dietary Manager (CDM) , Employee Identifier (EI) #3, stated, "As long as it's in the blue, I'm good." On 07/24/19 at 3:10 PM, the surveyor interviewed the Auto-Chlor Technician, who had been called in to check the dish machine. At this time, the Auto-Chlor Technician affirmed the gauge was reading good and affirmed a temperature reading in the blue area of the gauge indicated a temperature to be be too cool. Due to the difficulty in determining the water temperature, the Auto-Chlor Technician stated he would install a different gauge, making it easier to read. On 07/25/19 at 8:15 AM, a dishwasher, EI #4, had again documented the machine temperatures as 130 degrees for the wash and 140 degrees for the rinse. When asked, EI #4 demonstrated how she checked the temperatures, by squatting down and bending her head under the counter. She stated, "It's in the blue section." At the surveyor's request, EI #3, ran another cycle of dishes. The surveyor observed the gauge to be reading in the yellow section at about 125 degrees. EI #3 stated, "It's impossible to read." EI #3 stated she would contact the Auto-Chlor Technician again, and request documentation to ensure it was permissible to check the machine's reservoir with a food thermometer to determine the water temperature.	F 908	section of the 2017 Food and Drug Administration Code related to Mechanical Warewashing Equipment and required temperatures for washing and sanitizing the dishes used in this environment. Lastly the Sanitation Inspection Checklist will be trained to all Dietary Staff and later used for monitoring the effectiveness of these trainings. Training will be conducted by the Registered Dietician/Designee to be completed by 8/29/2019. Any of the required staff who has not been trained by this date will not be allowed to work until the training has been complete. The same training will be provided to any new hires during orientation by the Dietary Manager. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. A DAILY Dishwashing Machine Temperature Log using the Dishwashing Gauge as the Thermometer will be logged three times a day. Any deviations from the Manufactures Guideline specified on the Temperature Log will be immediately reported to the Maintenance Staff and or AutoChlor Technician. This document will be reviewed and initialed by the CDM DAILY for 6 months beginning July 26, 2019. Beginning 8-22-2019 the Sanitation Inspection Checklist will be performed and completed weekly x4 weeks and monthly from now on. Five additional months, (after the four weeks) will be completed by the CDM and/or the Registered Dietician. Additional education and /or discipline will	

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F 908	Continued From page 9 On 07/25/19 at 9:30 AM, the surveyor video scanned the temperature gauge with a cell phone camera to reveal the following readings on the gauge: Blue section=90-118 degrees F Yellow section=118 to 134 degrees F Green section=136 to 148 degrees F Red section=150-162 degrees F After viewing the video, the above temperatures were agreed upon by EI #3 and EI #6, Dietary Aide and the surveyor. On 07/25/19 at 9:30 AM, the Auto-Chlor Technician returned to the dish room and stated, "The gauge is wrong." The Auto-Chlor Technician brought a larger and easier to read gauge, showing it to both EI #3 and to the surveyor. CONNIE PAVELEC, NUTRITION/DIETITIAN SHEILA COOPER, REGISTERED NURSE CYNTHIA RICHARDSON, REGISTERED NURSE	F 908	immediately take place when deficits occur contrary to the Policies and Procedures of this facility concerning the operation of the Dietary Department. All monitoring tools will be reviewed by the Administrator and placed in the Plan of Correction Binder in the Administrators office. In addition a copy of the monthly Auto Chlor Technician's report will placed in the Plan of Correction binder for a 6 month period.	