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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Manor Nursing Home	3891 Sullivan St Madison, AL 35758

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on record review, interview, review of facility investigation, and facility policy review, the facility failed to ensure one (Residents (R) R63) of nine residents reviewed for abuse were protected from abuse, specifically staff to resident verbal abuse. Refer to F609 Findings include: Review of the facility's policy titled, Abuse Policy, dated October 2022, revealed It is the policy of [Facility]to ensure that each resident is free from verbal, sexual, physical, and mental abuse, neglect, misappropriation of resident's personal property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms .each new employee will receive education regarding the facility policies concerning resident rights and physical, verbal, mental and sexual abuse, corporal punishment, involuntary seclusion, and misappropriation of resident's personal property to include methods of properly reporting any such alleged violation of resident rights .Training includes appropriate intervention methods that may become necessary to remove a resident from potential harm in the event that a resident or visitor exhibits aggressive or catastrophic behavior .The facility must also initiate an immediate investigation and take all necessary steps to prevent further potential abuse. Examples of steps that the facility may put in place immediately to prevent further potential abuse include suspension of any employee who is alleged to have participated in an abusive incident .An investigation of the incident must be initiated immediately by the administrator or his/her designee. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to DHCF and to adult protective services and local law enforcement in accordance with State law. Review of R63's undated Admission Record, located under the Profile tab in the EMR, revealed R63 was admitted to the facility on [DATE] with a diagnoses that included Alzheimer's disease with mood disturbance, dementia, and peripheral vascular disease (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Madison Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3891 Sullivan St Madison, AL 35758	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R63's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24, revealed a Brief Interview for Mental Status (BIMS) with a score of 99, which indicated severe cognitive impairment. The resident was documented as dependent for toileting and personal hygiene and required substantial/maximal assistance with rolling left and right. A 08/03/23 physician progress note documented the resident with moderate cognitive deficits. Review of the facility's Incident Report, provided by the facility, revealed that on 08/03/23 at approximately 2:15 PM, revealed that While providing therapy to a resident in 7A, therapist [Speech Therapist (ST)] heard Certified Nursing Assistant (CNA)2 say to R63 who was behind the privacy curtain, Your [expletive] stinks. Review of the 08/04/23 Self-Report Summary provided by the facility, which documented, in part, that The therapist followed the CNA into the hallway and told her we do not speak to residents in that manner, because it could have been very hurtful. The facility investigation substantiated the verbal abuse of CNA2 to R63 and the staff member was terminated. During an interview on 08/15/24 at 1:33 PM, ST stated that she was in R63's room working with the resident's roommate, with the privacy curtain pulled. ST said that while R63 was being changed, CNA2 said, (R63) your [expletive] stinks. ST said that CNA2 said it in a nonaggressive way and the resident was not in danger, but it was inappropriate. ST said R63's memory is very poor, and he would not have remembered it at that time or now. She said she stepped into the hallway with CNA2 and told her she could not speak to residents in that way. She said that she made a mental note of what happened and to go to the Nursing Home Administrator after she was done working with her resident. She said that CNA2 had left for the day, when she had reported and written up what had happened. She confirmed CNA2 never returned to the facility. ST stated that she had received abuse training and was given additional training afterwards. She said that she should have reported it immediately. During an interview on 08/15/24 at 1:44 PM, interim Director of Nursing said that she was the staff developer at the facility when the situation occurred. She said that she found out on 08/04/23, the day after. She said that ST had reported to the supervisor, who had reported to the Nursing Home Administrator and then she found out. She stated that she went to speak with R63 but he did not recall the incident. She called the resident's family, and CNA2 was terminated. She said that CNA2 stated that she had not meant anything by it, but confirmed she said it. ST should have reported it immediately. Interim Director of Nursing said that the facility had a brief time to report the incidents, ST was written up and was reeducated. She said that she provided additional reporting education to staff. She said that R63 has not had any ongoing concerns. She confirmed that the facility tried to get their abuse incidents in within two hours, which would be reported by the Nursing Home Administrator regardless of the day it occurred and could be reported from home. During an interview on 08/15/24 at 2:14 PM, Nursing Home Administrator stated that ST did not report the situation timely. She said that she initiated the incident report as soon as she had heard about it. She confirmed that the ST had disciplinary actions, and there was staff retraining. Nursing Home Administrator stated that CNA2 was terminated for abuse. She said that when she had been informed of the abuse incident she had been at home and did not have internet service due to weather. She said that she came to the facility to report but also had no service. She said that she reported the incident when internet access returned on 08/04/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER: Madison Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 3891 Sullivan St, Madison, AL 35758	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on staff interviews, record review, and facility policy review, the facility failed to ensure an abuse allegation by of staff to resident (Resident (R) 63 and resident to resident abuse (R26 and R66) of nine residents reviewed for abuse were reported in a timely manner. Specifically, the facility failed to ensure an initial incident report was submitted to the state survey agency within two hours. Findings include: Review of the facility's policy titled, Abuse Policy, dated October 2022, revealed It is the policy of {Facility}to ensure that each resident is free from verbal, sexual, physical, and mental abuse, neglect, misappropriation of resident's personal property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms .each new employee will receive education regarding the facility policies concerning resident rights and physical, verbal, mental and sexual abuse, corporal punishment, involuntary seclusion, and misappropriation of resident's personal property to include methods of properly reporting any such alleged violation of resident rights .Training includes appropriate intervention methods that may become necessary to remove a resident from potential harm in the event that a resident or visitor exhibits aggressive or catastrophic behavior .The facility must also initiate an immediate investigation and take all necessary steps to prevent further potential abuse. Examples of steps that the facility may put in place immediately to prevent further potential abuse include suspension of any employee who is alleged to have participated in an abusive incident .An investigation of the incident must be initiated immediately by the administrator or his/her designee. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to DHCF and to adult protective services and local law enforcement in accordance with State law. 1. Review of R63's undated Admission Record, located under the Profile tab in the EMR, revealed R63 was admitted to the facility on [DATE]. Review of R63's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24, revealed a Brief Interview for Mental Status (BIMS) with a score of 99, which indicated severe cognitive impairment. The resident was documented as dependent for toileting and personal hygiene and required substantial/maximal assistance with rolling left and right. A 08/03/23 physician progress note documented the resident with moderate cognitive deficits. Review of the facility's Incident Report, provided by the facility, revealed that on 08/03/23 at approximately 2:15 PM, revealed that While providing therapy to a resident in 7A, therapist [Speech Therapist(ST)]heard [Certified Nursing Assistant (CNA)2] say to R63 who was behind the privacy curtain, Your [expletive] stinks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Manor Nursing Home	3891 Sullivan St Madison, AL 35758

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided Confirmation of Receipt of Online Incident Report revealed that the facility reported incident had occurred on 08/03/23 at 2:15 PM. The report was submitted on 08/04/23 at 9:48 AM. Review of the Facility Reported Incident, provided by the state survey agency revealed the facility reported incident on 08/04/23 at 9:48 PM, which confirmed the facility did not report the incident until approximately 19 hours after the incident. During an interview on 08/15/24 at 1:33 PM, ST stated on 08/03/23 at approximately 2:15 PM while she was in R63's room working with the resident's roommate, with the privacy curtain pulled. ST said that while R63 was being changed, CNA2 said, (R63) your [expletive]stinks. ST said that CNA2 said it in a nonaggressive way and the resident was not in danger, but it was inappropriate. ST said R63's memory is very poor, and he would not have remembered it at that time or now. She said she stepped into the hallway with CNA2 and told her she could not speak to residents in that way. She said that she made a mental note of what happened and to go to the Nursing Home Administrator after she was done working with her resident. She said that CNA2 had left for the day, when she had reported and written up what had happened. She confirmed CNA2 never returned to the facility. ST stated that she had received abuse training and was given additional training afterwards. She said that she should have reported it immediately. During an interview on 08/15/24 at 1:44 PM, Interim Director of Nursing said that she was the staff developer at the facility when the situation occurred. She said that she found out on 08/04/23, the day after. She said that ST had reported to the supervisor, who had reported to the Nursing Home Administrator and then she found out. She stated that she went to speak with R63 but he did not recall the incident. She called the resident's family, and CNA2 was terminated. She said that CNA2 stated that she had not meant anything by it, but confirmed she said it. The Interim Director of Nursing stated ST should have reported it immediately. Interim Director of Nursing said that the facility had a brief time to report the incidents, ST was written up and was reeducated. She said that she provided additional reporting education to staff. She said that R63 has not had any ongoing concerns. She confirmed that the facility tried to get their abuse incidents in within two hours, which would be reported by the Nursing Home Administrator regardless of the day it occurred and could be reported from home. During an interview on 08/15/24 at 2:14 PM, Nursing Home Administrator stated that ST did not report the situation timely. She said that she initiated the incident report as soon as she had heard about it. She confirmed that the ST had disciplinary actions, and there was staff retraining. Nursing Home Administrator stated that CNA2 was terminated for abuse. She said that when she had been informed of the abuse incident she had been at home and did not have internet service due to weather. She said that she came to the facility to report but also had no service. She said that she reported the incident when internet access returned on 08/04/23.

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NAME OF PROVIDER OR SUPPLIER Madison Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3891 Sullivan St Madison, AL 35758	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, medical record reviews, and interviews, the facility failed to prevent accidents for one resident (R)36) of 31 sampled residents. Specifically, a Certified Nurse Aid (CNA) 1 attempted to transfer R36 without assistance during and after the resident's shower. Findings include: Review of the Facesheet found in the electronic medical record (EMR) indicated that R36 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, history of falls and chronic pain syndrome. Review of R36's quarterly Minimum Data Set (MDS) found under the MDS tab of the EMR with an assessment reference date (ARD) of 05/21/24 revealed R36 required extensive to dependent level of assistance (helper does ALL of the effort for task) with transfers, bathing and dressing. R36 was unable to ambulate independently and required assistance of at least one staff for all mobility needs. R36's undated care plan was for extensive to dependent assist from staff for transfers and bathing/showers. During a observation on 08/14/24 at 12:10 PM, CNA1 was observed transporting R36 from the shower room to the beauty shop. CN 1 used her left hand to push/guide R36's wheelchair; while attempting to move an empty mechanical lift with her right hand. As the wheelchair moved down the hallway R36's right foot bent under the chair with her toes pointed behind her. The resident could not reposition her foot herself, and she mumbled to the CNA that her foot hurt. It took a moment for the CNA to hear and understand what R36 was saying. CNA1 stopped as quickly but the incline caused the wheelchair to continue to move forward several feet, pinning the resident's foot underneath her with toes pointing behind her. When CNA1 brought the wheelchair to a complete stop, she tried to reposition R36's foot and the resident cried out in pain. Registered Nurse (RN) 1 was passing in the hallway and stopped to assist CNA1 and R36. The resident's foot was brought back to a natural position and no obvious injury was noted when she was assessed, other than the resident stating it hurt. In an interview with Licensed Practical Nurse (LPN) 1 at 1:00PM on 08/14/24 revealed LPN 1 was the charge nurse on the back hallway when this incident occurred. LPN1 had spoken to and provided reeducation to CNA1. LPN1 stated the CNA was distraught about the incident and tearfully stated that she was trying to do too much, and she should have waited for another staff member to assist her, .I should have gotten R36 to the beauty shop and come back to move the lift. LPN1 confirmed the facility's policy is, .all transfers requiring a mechanical lift require a minimum of two staff members to prevent these types of accidents . CNA 1 was present & tearfully said, . I was trying to do too much and hurrying to get her to the beauty shop . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator at 08/14/24 at 2:30PM, she stated a mobile Xray was ordered, and completed and the results were pending. She stated the CNA was re-educated and the appropriate notifications were made to the physician and R36's daughter/Power of Attorney (POA). The Administrator stated there was no policy that would specifically address these circumstances. The Administrator provided CNA1's initial training and competency check off document, completed on 07/12/24, related to transfers and using mechanical lifts. The Administrator also provided a copy of the re-education provided to the CNA1 immediately following this incident on 08/14/24. On 08/15/24 at 8:30 AM R36 was visited in her room. She was sitting in her wheelchair after breakfast. She was dressed and groomed for the day and wearing clogs. The shoe was easily removed by LPN 1 and R36 had mild bruising/discoloration to her right foot/ankle, but no serious injury. The resident did not appear to remember the incident the day before in her wheelchair when she was asked. During an interview on 08/15/24 at 9:15 AM the Administrator confirmed the Xray results were negative for fracture to R36's right foot/ankle. She stated the incident prompted an opportunity for reeducating staff on the importance of two person/staff transfers for dependent residents.