

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105807	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2481 West US 90 Madison, FL 32340	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observations and interviews, the facility failed to maintain the laundry room area in a clean and sanitary [NAME] and failed to maintain laundry equipment in proper working condition. The findings include: (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A tour of the laundry room was conducted with Staff J, a Laundry Services Aide, on 08/15/24 at 8:35 AM. Upon entering the laundry room, the surveyor observed 2 washing machines and 2 dryers present in the same room. When asked if all the machines were working properly, Staff J stated the first washing machine had been leaking for a while and they had to use a garbage can to catch the water leaking from the door of the machine. The surveyor observed a piece of fabric wrapped around a plastic pipe which went from the side of the washing machine to the door of the washing machine. Further observation revealed water was leaking from this pipe and down the door of the machine despite the machine not being turned on. Closer observation revealed there was no floor drain in the room, which could result in a slipping hazard for the staff. Staff J stated the water would fill the whole floor of the room if the garbage can was not present to catch it. She further stated they had to empty the garbage can multiple times per day as it would fill up with water from the machine. When asked to clarify how long this washing machine had been leaking, Staff J stated it had been 6 to 8 months. She further stated the facility was aware of this issue but that she had been told that parts were not available to fix this washing machine because of its age. Continued observation revealed both washing machines had buckets located behind them which contained numerous foreign objects, including coins, pens, straws, lint, gloves, bandages, and other unidentified matter. When asked how often these buckets are cleaned out, Staff J stated she did not know. Further observation in the laundry room revealed a large number of uncovered pillows which were stacked on a counter next to the washing machines and adjacent to the handwashing sink. This could result in contamination to the pillows from the washing machines or the sink. When asked why these pillows were in the laundry room, Staff J stated the pillows used to be kept in the resident's rooms, but the previous laundry manager told the staff the pillows had to be kept in the laundry room in plastic bags to keep them clean for resident use. The surveyor also observed linens stacked on a shelf next to the handwashing sink which were uncovered. This could result in contamination to the linens from the sink. Two cardboard boxes were located under the sink which could be a tripping hazard for the staff. In the clean linen area, the surveyor observed there were clear shower curtain liners being used to cover the linens on the shelves. There was one area of the shelving which was uncovered. The surveyor observed there were mop heads being stored above the uncovered clean linen area. Staff J told the surveyor that the shower curtain liners often became ripped by the staff or fell off because they were only held on by tape and that they had to be replaced often. An interview was conducted with the facility's Administrator on 08/15/24 at 9:00 AM. The administrator stated he was aware that the washing machines were leaking. He stated he was aware that the staff was using a garbage can to collect the water from the washing machine. When asked why the washing machine was not fixed for 6 to 8 months, he stated he would call to his supplier to see if parts were available. The surveyor explained the concern was that the facility was aware that the machine leaking caused a hazard to the staff and that nothing was done until the surveyor intervened.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43857 Based on observations, interviews, record review, and facility policy review, the facility failed to implement a care plan for 1 of 1 resident reviewed for respiratory care. (Resident #7) The findings include: On 8/13/24, an observation of Resident #7 revealed oxygen equipment next to her bed including an oxygen concentrator, an undated nasal cannula, and a humidifier. On 8/13/24 at 1:18 PM, an interview was conducted with Resident #7. She revealed using oxygen at night. She further stated staff would assist her with donning and doffing the nasal cannula every day. A review of Resident #7's medical record was conducted. The resident was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A review of all current and active physician's orders did not include oxygen. A review of the resident's Treatment Administration Record (TAR) revealed no documentation for oxygen care and services. A review of the care plan revealed an intervention that included oxygen settings: oxygen via nasal cannula per physician's orders. On 8/15/24 at 10:42 AM, an interview was conducted with Staff B, a Certified Nurse Assistant (CNA). He stated he had been assisting Resident #7 doffing nasal cannula every morning. On 8/15/24 at 10:46 AM, an interview was conducted with Staff D, a Licensed Practical Nurse (LPN) and Minimal Data Set (MDS) coordinator. She reviewed Resident #7's care plan and stated the resident should have a physician's order for oxygen and confirms the care plan had not been implemented. She further stated she probably went to the hospital and when she came back they missed the oxygen orders. A review of facility policy Nursing: oxygen administration was conducted. The policy stated the purpose of this procedure was to provide guidelines for oxygen administration. Bullet 9 stated turn on the oxygen. Start the flow of oxygen at the prescribed rate. A review of facility policy Person Centered care planning was conducted. Policy stated: When admitted , each resident will have physician orders, dietary needs, medications, treatments, and preliminary discharge plans reviewed by the IDT and will have an interim care plan developed within 24 hours of admission, along with input from the resident and/or representative. Resident assessments are initiated on the first day of admission and completed no later than the 14th day after admission. A comprehensive care plan is completed within 7 days of completing the resident assessment. Daily review of the preceding day's physician orders is one was to continually be aware of any changes in a resident's condition. Care plans are reviewed, at a minimum, quarterly.		