STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policies, the facility failed to 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 for five of 28 residents on three of three separate hallways.The findings include: Review of the facility's policy titled, Residents Rights Standards of Practice, origination date 04/2024, revealed the facility would ensure each resident was treated with respect and dignity, and cared for in a manner that promoted maintenance or enhancement of their quality of life. Review of the facility's policy titled, Infection Control, Revised 10/2018, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage the transmission of diseases and infections. Review of the facility's policy titled, Isolation – Categories of Transmission-Based Precautions, undated, revealed standard precautions were to be used when caring for residents at all times regardless of their suspected or confirmed infection status. Continued review revealed appropriate notification was to be placed on the room entrance door and in the front of the chart so that personnel and visitors were aware of the need for and the type of precaution to be utilized. The signage informed the staff of the type of CDC precaution(s), instructions for use of Personal Protective Equipment (PPE), and/or instructions to see a nurse before entering the room. Review of the facility's policy titled, Hand Hygiene, undated, revealed hand hygiene was required to be performed by staff at medication preparation areas and after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. Review of the facility's policy titled, Cleaning and Disinfection of Resident Care items and Equipment, revision date 04/2025, revealed resident-care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupation Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. Continued review revealed objects that enter sterile tissue (e.g. urinary catheters), or the vascular system (e.g. intravenous catheters) were considered critical items and must be sterile. Further review revealed respiratory therapy equipment should be free from all microorganisms, although small numbers of bacterial spores were permissible. Review of the Lippincott procedure Manual Nineth Edition revealed maintaining a closed drainage system was essential to minimize the risk of infection. Furthermore, wipe all connecting junctions with alcohol prior to reconnecting tubing. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Enhanced Barrier Precautions signage posted outside of the residents' rooms throughout the survey stated the following: Everyone must clean their hands, including before entering and when leaving the room. 1a. Observation on 07/22/2025 at 8:30 AM revealed oxygen tubing unbagged and, on the floor, and a second oxygen tubing unbagged on a sink in a resident's room. b. Observation, on 07/22/2025 at 9:15 AM, revealed Licensed Practical Nurse (LPN) 1 removed medications from the packet and placed the medications in his/her ungloved hands before placing the medications into a container to administer the medications to a resident. In an interview with LPN1, on 07/23/2025 at 8:16 AM, LPN1 stated she should not have placed medications into her ungloved hands, adding, that was an accident. LPN1 continued to state not following proper infection control protocols could spread infections that could make residents sick, cause them to be hospitalized , or die. c. Review of R7's admission Face Sheet revealed resident was admitted on 0611/2025 with corticobasal deterioration, dementia, and urinary tract infection (UTI). Review of R7's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/16/2025, revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15, which indicated moderately impaired cognition. Review of R7'2 Physician order dated 07/07/2025 revealed R7 was on contact precautions due to a UTI. During observation on 07/22/2025 at 9:25 AM, with Licensed Practical Nurse (LPN)4 and State Registered Nurse Aide (SRNA) 5, entered the room of R7 due to R7 partially sliding out of bed onto fall mat. R7 was noted to have enhanced barrier precaution signage outside the room door. LPN4 and SRNA 5 entered the room with gloves only. R7 was also noted to have had a bowel movement and had pulled brief partially off. Both LPN4 and SRNA5 continued to provide care with gloves only. Further observation revealed R7 had pulled the foley catheter from the drainage tubing. The foley was still in place to R7, the disconnected end was lying in the bed under the resident. LPN4 was noted to pick up the drainage tubing, and catheter end and reconnect without cleaning ends. During an interview on 07/23/2025 at 8:13 AM with LPN4 she stated she was aware she should have followed the Enhanced Barrier Precautions that included handwashing prior to entering the room, donning gown, and then handwashing following care. LPN 4 further stated she was in a pressing matter and needed to rush due to R7 sliding out of bed. Further interview with LPN4 she stated she should not have reconnected the foley catheter back to drainage tubing prior to cleaning. LPN4 stated not following the infection control precautions could cause infection to spread others. She further stated she had been educated on infection control. During an interview on 07/23/3035 at 2:40 PM with SRNA5, she stated she was aware she needed to use appropriate Personal Protection Equipment (PPE) and follow the enhanced barrier precautions as indicted on the signage but felt the resident safety was most important at the time she entered the room, and he was sliding out of the bed. She stated not donning appropriate PPE could cause spread of infection to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/2025 at 11:48 AM with the Director of Nursing (DON) she stated the facility followed the Lippincott Manual guidelines for foley catheter care and did not have a policy for urinary catheter change and care. She further stated she expected staff to follow aseptic technique with d. Observation, on 07/22/2025 at 11:37 AM, revealed Respiratory Therapist (RT) 1 entered resident rooms with Enhanced Barrier Precaution signage posted on the entrance door and changed residents' oxygen tubing without washing their hands before entering or after exiting the resident room. During an interview, on 07/23/2025 at 3:20 PM, RT1 stated when he changed oxygen tubing, he did not wash his hands before entry or after exiting the room, regardless of whether the room had contact precaution signage or enhanced barrier precaution signage. RT1 stated not following proper infection control policies could lead to the spread of viruses to residents. RT1 stated he was not aware of the facility's infection control policies. e. Observation and interview, on 07/23/2025 at 5:35 AM, revealed Certified Nursing Assistant (CNA) 1 exited a resident's room with Enhanced Barrier Precautions signage on the door while wearing an isolation gown. During an interview, CNA1 stated she should have removed her isolation gown prior to exiting the resident's room. CNA1 further stated she had received education on infection control and not removing her gown in the resident's room could spread germs to other residents. During an interview, on 07/23/2025 at 6:20 AM, LPN2 stated staff were in a hurry this morning, and she would not be surprised that staff were not wearing PPE when performing resident care in a room marked with Enhanced Barrier Precautions. LPN2 continued to state that not following proper infection control policies could allow infections to spread between residents and staff, leading to sickness or death. The Regional Quality Nurse 1 stated in interview on 07/23/2025 at 10:00 AM, she had not performed staff training at the facility. Further, the Regional Quality Nurse 1 stated she would not have expected staff entering or exiting an enhanced barrier precaution room to wash their hands if they did not have direct contact with a resident, even though the facility signage stated everyone should wash their hands before entry and after exiting the resident's room. During an interview, on 07/23/2025 at 1:53 PM, the Wounds Nurse 1 stated medications should never be touched with bare hands as it could lead to widespread infection issues that could result in sickness, hospitalization, and death. The Infection Preventionist stated in interview, on 07/23/2025 at 2:47 PM, it was his expectation for staff to wash their hands before and after changing oxygen tubing, to prevent infections, such as pneumonia, which could happen if staff did not follow correct infection control protocols. The Infection Preventionist stated it was his expectation for all staff to follow infection control protocols to ensure the safety of residents. During an interview, on 07/24/2025 at 11:48 AM, the Director of Nursing (DON) stated she conducted walkthroughs of the facility to ensure staff were following infection control policies and she had seen staff being noncompliant with protocols, such as proper hand hygiene. The DON continued to state proper infection control protocols not being followed could lead to mass infection outbreaks that could lead to the death of residents. The DON stated she expected all facility staff to follow all policies and protocols. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator stated in interview, on 07/24/2025 at 11:31 AM, that if staff did not follow proper infection control protocols, it could lead to a global transmission of infection that could spread to residents, staff, or visitors, and depending on the resident's comorbidities, could lead to any number of negative outcomes. The Administrator stated it was his expectation for all staff to follow all policies and protocols set forth by the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, it was determined the facility failed to provide the residents with a right to a safe, clean, comfortable, and homelike environment for five of 28 sampled residents (Resident (R)6, R7, R64, R37and R48) on one of three hallways.The findings include:Review of the facility policy titled, Resident Rights undated, revealed the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living. On 07/23/2025 at 10:50 AM, observation of Resident (R)6's room revealed a black substance was on the floor around the baseboard. Continued observation of R6's room revealed three tiles were observed to be cracked in R6's bathroom floor.On 07/24/2025 at 10:48 AM observation of R7's room revealed a black substance on the baseboard of the bathroom. Parts of the baseboard was missing in R7's room around the air condition unit. On 07/24/2025 at 10:54 AM observation of R64's room revealed a black substance on the baseboards of the room. Continued observation revealed baseboards were missing underneath the air condition unit along with a hole in the wall under the bottom of the unit.On 07/24/2025 at 11:08 AM observation of R37's room revealed the wall had a crack in it behind R37's bed along with no baseboard behind the bed. Continued observation revealed a hole in the top of the tub near the faucet. On 07/24/2025 at 11:14 AM observation of the oxygen storage entrance revealed a black substance around the bottom of the door. In an interview with the Maintenance Director on 07/24/2025 at 11:42 AM, he stated When we get a work order, we try to prioritize how important they are, and we try to get them completed within 24 hours. According to the Maintenance Director, all staff had been educated to report any physical plant issues to maintenance, and he was responsible for ensuring that any physical plant issues were repaired. Further, he stated that anyone in the facility could submit a work order for repairs. The Maintenance Director stated that he checks every morning when he comes to work for new work orders. The Maintenance Director stated that he had not received any new work orders and was not aware of any broken or missing tiles, but added it was important to complete needed repairs to keep the residents from falling or getting hurt. During an interview with the Director of Nursing (DON) on 07/24/2025 at 12:13 PM, the DON stated that she was unaware of any black substance on the walls or baseboards of any of the resident rooms. The DON further stated that if there was something like that growing on the walls and baseboards, housekeeping should notify her, and they would have someone come in and look at it to determine what the black substance was and how to treat it. She stated the facility attempts to repair items as quick as possible, adding, We never want any kind of fall or incident to happen due to something we could have prevented. The DON stated her expectation was for staff was to observe for possible dangers within the facility and complete a work order for maintenance to resolve the environmental concerns. The Administrator stated in interview on 07/24/2025 at 12:42 PM that it was his expectation that anytime someone saw anything wrong with the building, they would complete a work order for maintenance to repair concerns identified. The Administrator further stated that residents should always have a clean and safe environment.