STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225475	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor Nursing Home	85 North Washington Street North Attleboro, MA 02760

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were accurately labeled and stored in accordance with acceptable professional standards. Specifically, in one of three medication carts reviewed the facility failed to ensure medications were stored in their original packaging. Findings include: Review of the facility's policy titled Medication Storage in the Facility, dated March 2021, indicated but was not limited to:-The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United State Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another.-All medications dispensed by the pharmacy are stored in the container with the pharmacy label. On 9/10/25 at 12:48 P.M., the surveyor observed a medicine cup containing several unlabeled medications, in the 2nd floor [NAME] Unit medication cart third drawer. The medicine cup included eight pills:-one red oval caplet-one dark red round tablet-one pink oval tablet-one white and blue capsule-two white round tablets-one dark (black) round pill -one white/yellow tablet During an interview on 9/10/25 at 12:51 P.M., Nurse #4 said the medications were for Resident #70 who refused to take the prescribed medications at 9:00 A.M. Nurse #4 said she should have destroyed the medications after refusal and should not have left the medications in the cart in a medicine cup unlabeled. During an interview on 9/11/25 at 2:20 P.M., the Director of Nursing (DON) said medications should not be left without identifiers, unlabeled, in a cup inside of the medication cart. The DON said if a resident refused medications those medications should be destroyed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents received food prepared by methods that conserve nutritive value, flavor and appearance and was palatable, attractive and at a safe and appetizing temperature for one of two test trays. Findings include:Review of Resident Council Minutes indicated the following resident concerns and facility solutions:- 7/3/25: food trays are warm, but not hot and meals are delivered at incorrect times. The Food Service Director (FSD) is training new staff, and the metal plate warmer was not functioning and was being fixed.- 8/7/25: FSD attended meeting and explained to residents the piece of equipment (metal plate warmer) that was not working in the main kitchen. On 9/10/25 at 11:00 A.M., 10 of 17 residents in attendance of the Resident Council Meeting said food was cool or lukewarm and that trays were coming later than scheduled. On 9/11/25 at 8:00 A.M., the surveyor requested a test tray to the second floor unit and made the following observations:- The food truck containing resident trays left the main kitchen at 8:13 A.M. and arrived at 8:14 A.M. on the unit and was placed across from the unit dining room.- At 8:15 A.M., nursing staff were observed on the [NAME] portion of the unit delivering meal trays to residents from the first meal truck sent to the unit. The second meal truck remained positioned across from the unit dining room, unopened.- At 8:21 A.M., a Certified Nursing Assistant (CNA) was observed to place a meal tray from the first meal truck into the second meal truck across from the unit dining room. The CNA then continued to deliver meal trays to residents from the first meal truck.- At 8:28 A.M., 14 minutes after the second meal truck arrived on the unit, nursing staff began delivering meal trays into the unit dining room from the second meal truck.- At 8:49 A.M., 35 minutes after the second meal truck arrived on the unit, nursing staff delivered the last meal tray from the meal truck. On 9/11/25 at 8:50 A.M., the surveyor and Nurse #3 completed the test tray together and the food temperatures were as followed:- Bacon: 100.5 Fahrenheit (F); bacon was crispy but cold to taste and touch- Scrambled Eggs: 113.2 F; eggs were cold and lacked flavor- Milk: 54.3 F; lukewarm temperature to taste and warm to touch- Orange Juice: 55.9 F; lukewarm to taste and touch-Hot Cereal: 125.8 F; warm to taste-Coffee: 135.1 F; hot, no concerns noted. During an interview on 9/11/25 at 8:51 A.M., Nurse #3 said she was not sure what temperatures should be when they arrive on the unit to residents. During an interview on 9/11/25 at 11:45 A.M., the FSD and the surveyor reviewed the observations and test tray results from the breakfast service. The FSD said cold items, such as milk and orange juice, should be around 40F when residents are consuming them on the unit. The FSD said hot food items should be around 150-155F when served to residents on the unit. The FSD said she would expect the hot food temperatures to be higher and the drink temperatures to be lower.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Ensure the main kitchen grout and coving was maintained in a sanitary and safe condition; and2. Ensure ready to eat foods (food which does not require cooking or further preparation prior to consumption) were handled utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another) during tray line service. Findings include:1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following:1-2 Definitions 1-201 Applicability and Terms Defined1-201.10 Statement of Application and Listing of Terms.Easily Cleanable.(1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use.Smooth means:(3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean.6-201.12 Floors, Walls, and Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized.6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch). On 9/9/25 at 8:20 A.M., the surveyor made the following observations in the main kitchen:- Peeling paint on the ceiling above the air conditioner and prep sink.- Dirty floor tiles under the sinks in the food prep area.- Chipped/peeling paint on the ceiling and walls in the first walk-in refrigerator.- Chipped/peeling paint on the ceiling and walls in the second walk-in refrigerator. The ceiling and walls were also noted to have a white/brown powdery substance.- Black, fuzzy buildup on the tile coving in the second walk-in refrigerator.- Chipped/peeling paint on the ceiling and walls in the third walk-in refrigerator. The ceiling was also noted to have black splotches.- The perimeter of the floor in the third walk-in refrigerator had a buildup of crumbs and other food residue.- Grout in the dish room was noted to be crumbling in many areas. During an interview on 9/10/25 at 1:40 P.M., the Food Service Director (FSD) said the floors in the main kitchen areas are mopped twice a day by staff. The FSD said the floors in the main kitchen area had not been professionally washed or maintained since she started at the facility. The FSD said there were multiple areas of peeling paint in the walk-in refrigerators which will need to be addressed. The FSD when the paint peelings drop into the grout on the floor it is hard to get out. During an interview on 9/10/25 at 2:16 P.M., the Administrator and the surveyor reviewed the findings in the main kitchen areas. The Administrator said he expected the kitchen areas to be kept clean and sanitary. 2. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:- 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT.- 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On 9/10/25 at 11:26 A.M., the surveyor made the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following observations during the lunch tray line service:- At 11:33 A.M., Dietary Staff #1 touched the top of the trash can with a gloved hand and then used the same gloved hand to flip a grilled cheese sandwich cooking on the stove top.- At 11:42 A.M., Dietary Staff #1 went into the walk-in refrigerator to grab food items for the line service. Dietary Staff #1 did not change his gloves and returned to prepping foods on the tray line.- At 11:46 A.M., Dietary Staff #1 took a hot dog out of the warmer with gloved hands and continued to plate food items on the tray line without changing his gloves.- At 11:47 A.M., Dietary Staff #1 touched the broccoli, placing it in a bowl, and did not change his gloves.- At 11:50 A.M., Dietary Staff #1 adjusted his pants with his gloved hands and did not change them prior to continuing to plate food items during the tray line service.- At 11:53 A.M., Dietary Staff #2 touched his gloved hand to his face to just above his mouth. Dietary Staff #2 did not change his gloves and remained on the tray line placing items onto resident trays.- At 11:59 A.M., Dietary Staff #1 used his gloved hands to slide a grilled cheese onto a plate that he removed from the warmer.- At 12:00 P.M., Dietary Staff #1 used his gloved hands to plate French fries from the warmer onto a plate.- At 12:03 P.M., Dietary Staff #1 used his gloved hands to move a piece of meatloaf from a regular plate to a lipped plate.- At 12:15 P.M., Dietary Staff #3 touched her gloved hands to her face and adjusted her glasses and remained on the tray line without changing her gloves.- At 12:17 P.M., Dietary Staff #1 reached into a pot on the stove with his gloved hand and mixed the food item with his gloved hands. Dietary Staff #1 then plated the food item and delivered it to the tray line. During an interview on 9/10/25 at 1:40 P.M., the FSD said staff should be changing their gloves when they break away from a task or start something new. The FSD said dietary staff should change their gloves and perform hand hygiene if they touch their face or body. The FSD said gloves should have been changed when Dietary Staff #1 touched the top of the trash can.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interview and record review, the facility failed to ensure one Resident (#9), out of a total sample of 18 residents, was referred to see a Neurologist as recommended by the Psychiatrist and the Primary Physician.Findings include:Resident #9 was admitted to the facility in October 2022 with a diagnosis of history of bipolar disorder and anxiety.Review of the Minimum Data Set (MDS) assessment, dated 7/2/25, indicated Resident #9 scored 10 out of 15 on the Brief Interview for Mental Status, indicating the Resident had a moderate cognitive impairment. Review of Section S indicated Resident #9 was their own healthcare decision maker. Review of the medical record indicated Resident #9 had a telehealth visit with the Psychiatrist on 6/16/25. The Subsequent Nursing Facility Visit summary indicated Resident #9 became weepy while talking about his/her condition of involuntary movements/tremors. The Recommendations section indicated Due to {his/her} concerns that tremors have been depressing for {him/her}, consider referral to Neurology for consultation and recommendations to follow-up on Parkinsonian tremors and clarify re: whether {he/she} has primary Parkinson's vs. neuroleptic-induced Parkinsonian tremors. The visit form was signed by the primary physician on 6/17/25 with a handwritten note okay with me.During an interview on 9/10/25 at 2:15 P.M., Resident #9 said the Psychiatrist had recommended he/she see a Neurologist about the tremors, but he/she had never heard anything after that and had not seen a Neurologist but would like to.Review of the Nursing Progress Notes included a note written on 6/17/25 which indicated Resident #9 was seen by the Psychiatrist with no new orders other than labs (blood work).Review of the medical record on 9/10/25, almost three months after the visit, failed to indicate Resident #9 had been referred to a Neurologist.During an interview on 9/11/25 at 12:24 P.M., Unit Manager #1 said she had not read the part of the Psychiatrist's recommendation that indicated Resident #9 should be referred to a Neurologist and that the physician had signed it and agreed. She said the referral to a Neurologist had not been made for Resident #9.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interviews, the facility failed to ensure infection prevention and control measures were implemented to prevent the potential transmission of infections for one Resident (#33), out of a total sample of three residents observed for medication administration. Specifically, the facility failed to ensure staff followed safe injection standard practices, by recapping used needles after the administration of insulin.Findings include:Review of the facility's policy titled Specific Medication Administration Procedures, dated March 2021, indicated but was not limited to the following:-Injectable medication administration: To administer medications via subcutaneous route in a safe and effective manner.-Discard syringe and needle in designated area.-Activate needle safety feature.-Do not recap needleReview of the Occupational Safety and Health Administration (OSHA) Fact Sheet (DSG FS-3519) titled Protecting Yourself When Handling Contaminated Sharps, dated 1/2011, indicated sharps are objects that can penetrate a worker's skin, such as needles If blood or other potentially infectious materials (OPIM), as defined in the OSHA Bloodborne Pathogens standard (29 CFR 1910.1030), are present or may be present on the sharp, it is a contaminated sharp and appropriate personal protective equipment must be worn. A needlestick or a cut from a contaminated sharp can result in a worker being infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other bloodborne pathogens. The standard specifies measures to reduce these types of injuries and the risk of infection. Careful handling of contaminated sharps can prevent injury and reduce the risk of infection. Employers must ensure that workers follow these work practices to decrease the workers' chances of contracting bloodborne diseases. Resident #33 was admitted to the facility in April 2025 with diagnoses including Type II Diabetes.Review of Resident #33's Physician's Orders included the following:-Basaglar KwikPen U-100 Insulin 35 units subcutaneous (SQ) once a day-Novolog U-100 Insulin 4 units SQ with breakfast in addition to sliding scale. Hold for blood sugar under 100.On 9/10/25 at 9:11 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #33 which included the following:-Nurse #1 stated she had already taken Resident #33's blood sugar, and it was 107. She prepared both insulin injections at the medication cart as ordered and walked down the hallway and entered Resident #33's room, leaving her medication cart across from the nursing station.-Nurse #1 cleansed Resident #33's left lower abdomen with an alcohol swab and injected the Novolog insulin syringe.-Nurse #1 did not activate the needle safety feature leaving the used needle exposed, placed the cap over the used needle and placed it on Resident #33's overbed table.-Nurse #1 cleansed Resident #33's left upper abdomen with an alcohol swab and injected the Basaglar insulin pen.-Nurse #1 placed a cap over the used insulin pen and placed it on Resident #33's overbed table. The needle safety feature was activated, and no exposed needle was observed.-Nurse #1 then picked up the used insulin syringe and insulin pen, exited Resident #33's room, and walked down the hallway to her medication cart. She removed the needle tip from the insulin pen and disposed of it along with the insulin syringe in the sharp container located on the side of her medication cart.During an interview on 9/10/25 at 2:50 P.M., Nurse #1 said after administering injections, she should never recap a used needle. She said the insulin syringes should retract into the barrel after use and she does not know why it did not. Nurse #1 said she usually brings her medication cart into the doorway to dispose of the needles after use but was nervous and forgot. Nurse #1 said she recapped the used needles to carry them down the hallway to dispose of them in the sharp container located on her medication cart.During an interview on 9/11/25 at 1:52 P.M., the Director of Nursing (DON) said her expectation is for needle safety guidelines to be always followed, as a standard of practice. She said used needles are never recapped whether the needle is exposed or not. DON said the nurse should never carry used needles down the hallway.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on employee record review and interview, the facility failed to ensure the new hire employee records contained evidence of the 2024-2025 COVID-19 vaccination for two of five newly hired employees. Specifically, the facility failed to ensure the employee record contained evidence of the COVID-19 vaccination or proof the newly hired employees were offered an updated COVID-19 vaccine when he/she was eligible. Findings include: Review of the facility's policy titled COVID-19 Personnel Vaccination Requirement, dated as revised 5/2023, indicated but was not limited to:-All nursing homes must ensure that all personnel are up to date with vaccination against COVID-19, unless such administration is medically contraindicated or on the basis of a sincerely held religious belief-Vaccinations against COVID -19 will be made available to staff as arranged by the infection control nurse Review of the Centers for Disease Control and Prevention (CDC) guidance, Staying up to date with COVID-19 vaccinations, dated as revised June 6, 2025, indicated but was not limited to the following:- CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 years and older. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID.Importance of staying up to date:- Getting the 2024-2025 COVID-19 vaccine is important because protection from the COVID-19 vaccine decreases with time; Immunity after COVID-19 infection decreases with time; COVID-19 vaccines are updated to give you the best protection from the currently circulating strains.- Administer recommended vaccines if vaccination history is incomplete or unknown.- Routine vaccination: age [AGE]-64 years:a. Unvaccinated: 1 dose 2024-25 Moderna or Pfizer-BioNTech; 2 doses 2024-25 Novavax at 0, 3-8 weeksb. Previously vaccinated before 2024-25 vaccine with: 1 or more doses Moderna or Pfizer-BioNTech: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 dose Novavax: 1 dose 2024-25 Novavax 3-8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. 2 or more doses Novavax: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 or more doses [NAME]: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech.- Routine Vaccination: age [AGE] years and older:a. Unvaccinated: follow recommendations above for unvaccinated persons ages 19-64 years and administer dose 2 of 2024-25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).b. Previously vaccinated before 2024-25 vaccine: follow recommendations above for previously vaccinated persons ages 19-64 years and administer dose 2 of 2024-25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).- Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose. Nurse #1 was hired on 6/25/25. Review of the employee file failed to indicate evidence of his/her COVID vaccination status. Further review of the employee file failed to indicate he/she had been provided education regarding the benefits, risks, and potential side effects associated with the COVID vaccine; and had been offered the most recent COVID vaccination. Activities Assistant #1 was hired on 6/18/25. Review of the employee file failed to indicate evidence of his/her COVID vaccination status. Further review of the employee file failed to indicate he/she had been provided education regarding the benefits, risks, and potential side effects associated with the COVID vaccine; and had been offered the most recent COVID vaccination. During an interview on 9/1/25 at 9:31 A.M., the Assistant Director of Nurses (ADON)/ Staff Development Coordinator (SDC) said newly hired staff should bring a copy of their vaccine history with them at the time of hire and the information should be in the employee files. The ADON/SDC said the most recent COVID vaccine (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should also be offered to those who have not received it and it should be documented in their employee file. The ADON/SDC said if an employee did not want the vaccination a signed declination should be completed and kept in their employee file. During an interview on 9/11/25 at 1:16 P.M., the ADON/SDC said she could not find evidence of COVID vaccination or that the vaccination had been offered to Nurse #1 or Activities Assistant #1.