| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26E421 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Madison Medical Center | 611 West Main Street<br>Fredericktown, MO 63645 |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on interview and record review, the facility failed to maintain quarterly Quality Assurance & Performance Improvement (QAPI) meetings with the required members. The facility's census was 61.Review of the facility's policy, QAPI Program, dated July 2020, showed:- The QAPI team will meet on a monthly basis to discuss indicators and their performance, as well as other pertinent issues revolving around the operations of the facility. Representatives from the QAPI Team will also meet on a quarterly basis with physicians, nurse practitioners and other departments to report the tracking results of their indicators;- The policy did not address the required QAPI members. Review of the facility's 2024-2025 QAPI Plan showed: - The facility will improve quality within the organization by maintaining a Quality Improvement (QI) Team to oversee QI activities and evaluate QI process on an ongoing basis and to review policies and procedures relating to each function and to make necessary revisions. The QI Team includes leadership, medical staff representation, and department supervisors;- Leadership will review quality performance monthly with department directors, guiding them to meet goals;- A cross-functional team will be assigned for organization-wide functions. The team responsibilities include meeting on a periodic basis as established by the committee;- The Quality Improvement Director assures ongoing communication, reporting, and documentation of quality information by moderating QI discussions/reviews and holding QI meetings. Review of the facility's QAPI Meeting Minutes, provided by the Administrator, showed:- The Infection Preventionist (IP) did not attend the meeting on 11/15/24;- The physician or nurse practitioner (NP) did not attend the meeting on 02/14/25;- The physician or NP did not attend the meeting on 05/16/25. During an interview on 09/26/25 at 1:11 P.M., the Administrator said there is an IP on the hospital side, but it looks like there wasn't an IP at the November meeting. They will look at having another staff obtain the certification to become IP. Usually, the doctor or NP are at the meetings; she isn't sure why they aren't on the list or if they were there. She would expect all required members to be at the meetings. |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the statement of appeal rights or the name, address, or telephone number of the Office of the State Long Term Care Ombudsman (advocates for the residents in nursing facilities) within the transfer and discharge notices for seven residents (Resident #5, #7, #8, #21, #24, #37, and #43 ) out of 15 sampled residents. The facility's census was 61.Review of the facility's policy, Patient Transfer Form, revised July 2024, showed:<br><br>- The purpose is to provide pertinent information to the facility to which the resident is being transferred and to assure continuity of care;<br><br>- When a resident is being transferred to another facility for an out-patient care, acute care admission or emergency room care, the resident's Continuity of Care Document (CCD) will be printed from their electronic health record (EHR) and sent with them;<br><br>- The nurse will document a progress note regarding the resident's transfer;<br><br>- The nurse will complete the nursing home transfer/bed hold observation;<br><br>- Social Services will review and complete the bed hold notification;<br><br>- The policy did not address written notification of the transfer to the resident or resident's responsible party.<br><br>1. Review of Resident #5's medical record showed:<br><br>- admitted on [DATE];<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>2. Review of Resident #7's medical record showed:<br><br>- admitted on [DATE];<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Review of Resident #8's medical record showed:<br><br>- admitted on [DATE];<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>4. Review of Resident #21's medical record showed:<br><br>- admitted on [DATE];<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>5. Review of Resident #24's medical record showed:<br><br>- admitted on [DATE];<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- The resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>6. Review of Resident #37's medical record showed:<br><br>- admitted on [DATE];<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>7. Review of Resident #43's medical record showed:<br><br>- admitted on [DATE];<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- Resident transferred to the hospital on [DATE] and returned to the facility the same day;<br><br>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.<br><br>During an interview on 09/25/25 at 4:00 P.M., Registered Nurse (RN) C said when a resident goes to the emergency room (ER), they send a face sheet and there's another form where they answer questions. Nurses fill out a transfer/bed hold form and call the family and doctor.<br><br>During an interview on 09/26/25 at 10:57 A.M., the Social Services Designee (SSD) said he only sends the bed hold policy when a resident is hospitalized and not when they're sent to the ER. He does not ever send the transfer form. If they are sent to the ER and come back, he just notes Resident returned from the ER on the transfer form.<br><br>During an interview on 09/26/25 at 1:40 P.M., the Administrator said she would expect residents and their families to be notified in writing of their transfer or discharge from the facility.<br><br>During an interview on 09/26/25 at 3:36 P.M., the Administrator said the SSD does maintain a binder in his office for each transfer/discharge. The SSD does mail these out to the responsible party any time there is a transfer/discharge with the resident name and where they were sent.<br><br>During an interview on 09/30/25 at 2:59 P.M., the Chief Operating Officer said residents who are sent to the emergency room for evaluation are considered to be on therapeutic leave in the census and not classified as a transfer, as the Emergency Department is part of the facility. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and record review, the facility failed to maintain an error rate of five percent or less when medications were administered and staff failed to prime insulin pens before the administration of insulin. There were 25 opportunities with three errors made, for an error rate of 12%. This affected three residents (Resident #31, #42, and #50) outside of the 15 sampled residents, with the potential to affect all residents. The facility's census was 61.Review of the facility's policy, Insulin Administration, revised 01/24, did not address the use of insulin pens.Review of insulin lispro (Humalog) pen (insulin in a pen-type device) directions showed:- Remove cap;- Attach needle;- Prime pen by turning dose selector to select two units;- Press and hold button to make sure drop of insulin appears;- Select dose;- Give injection;- After dose counter reaches zero, hold for five to ten seconds;- After injection, remove needle and place in sharps container.1. Observation on 09/25/25 at 11:05 A.M. showed:- Licensed Practical Nurse (LPN) A obtained the finger stick blood sugar (FSBS) for Resident #31;- LPN A obtained the insulin lispro pen from the medication cart and adjusted the pen to the amount of insulin ordered;- LPN A did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident.2. Observation on 09/25/25 at 11:10 A.M. showed:- LPN A obtained the FSBS for Resident #42;- LPN A obtained the Humalog insulin pen from the medication cart and adjusted the pen to the amount of insulin ordered;- LPN A did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident.3. Observation on 09/25/25 at 11:15 A.M. showed:- LPN A obtained the FSBS for Resident #50;- LPN A obtained the Humalog insulin pen from the medication cart and adjusted the pen to the amount of insulin ordered;- LPN A did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident.During an interview on 09/25/25 at 11:20 A.M., LPN A said he/she doesn't prime pens, but they technically should be primed with two units of insulin. The reason that the pens aren't primed is the new needles the facility received are retractable and as soon as you let up off the button, the needle retracts, so there is no way to prime the needle. He/she is unaware if the problem has been discussed with the Director of Nursing (DON).During an interview on 09/26/25 at 1:40 P.M., the Administrator and DON said they would expect insulin pens to be primed before administering insulin and for the medication error rate to be 5% or less. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during wound care for two residents (Residents #10 and #56) out of two residents sampled for wound care. The facility's census was 61.Review of the facility's policy, Dressing Change, revised March 2023, showed:<br><br>- This is a clean procedure, not sterile;<br><br>- Check order for dressing change in the electronic treatment administration record (ETAR);<br><br>- Gather supplies, including a clean towel, paper towels or paper plate as a field for the dressing change and supplies;<br><br>- Wash hands at least 15 seconds and use friction, dry hands;<br><br>- Apply non-sterile gloves;<br><br>- Remove old dressing and throw in trash bag;<br><br>- Observe wound for redness, bleeding, and any kind of drainage, dried blood or odor;<br><br>- Remove gloves and put in trash;<br><br>- Wash hands at least 20 seconds, use friction and dry. Hand sanitizer is acceptable;<br><br>- Apply gloves;<br><br>- Gently clean wound as prescribed and pat dry with gauze pad or 4x4;<br><br>- If treatment requires ointment, use a small amount, apply to a cotton tip applicator or clean gauze pad, apply to open area and not surrounding skin;<br><br>- Cover wound as ordered by physician;<br><br>- Initial and date the tape applied to dressing;<br><br>- Remove gloves and wrap all trash in small bag and remove from room;<br><br>- Wash hands at least 15 seconds, use friction and dry. Hand sanitizer is acceptable;<br><br>- Document in the ETAR when you have completed the treatment.<br><br>Review of the facility's policy, Enhanced Barrier Precaution (EBP), dated May 2024, showed:<br><br>- The purpose is to protect residents and staff from multi-drug-resistant organisms by utilizing enhanced barrier precautions;<br><br>- Enhanced barrier precautions consists of donning gown and gloves;<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Staff will utilize EBP during high contact resident care activities for residents with any of the following: Infection or colonization with an MDRO (multi drug resistant organism) when Contact Precautions do not apply, wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status;<br><br>- High contact resident care activities include: dressing, bathing/showering, transfers, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing;<br><br>- Staff will change Personal Protective Equipment (PPE) before caring for another resident;<br><br>- All residents infected or colonized with MDRO will be placed on isolation precautions per infection preventionist or provider orders.<br><br>Review of the facility's policy, Handwashing, revised June 2024, showed:<br><br>- Personnel should decontaminate hands before direct contact with patients, before donning sterile gloves, after contact with mucus membranes or body fluids, when moving from contaminated site to clean or after touching inanimate source that might have been contaminated and after removing gloves;<br><br>- Wearing gloves does not replace the need for handwashing;<br><br>- Approved waterless sanitizer may be used in place of washing hands as long as hands are not visibly soiled.<br><br>1. Observation on 09/25/25 at 10:30 A.M. of wound care for Resident #10 showed:<br><br>- Registered Nurse (RN) B gathered wound supplies and entered the resident's room;<br><br>- RN B did not don a gown for EBP;<br><br>- RN B washed his/her hands in the resident's room;<br><br>- RN B picked up the resident's glasses off the floor, did not wash or sanitize his/her hands, and donned gloves;<br><br>- RN B removed the old dressing from a wound on the left breast, did not change gloves, and cleansed the area with gauze soaked in wound cleanser;<br><br>- RN B removed gloves and did not wash or sanitize his/her hands;<br><br>- RN B donned gloves and applied a small amount of calcium alginate (wound treatment) over the wound and applied tape to secure in place;<br><br>- Resident #10 complained of right breast pain. While wearing the same gloves, RN B assessed the resident's right breast;<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - RN B removed gloves, placed trash in the trash can, and washed his/her hands.<br><br>During an interview on 09/26/25 at 10:25 A.M., RN B said he/she should have put on a gown before doing wound care and wore it the whole time as he/she has been instructed to wear a gown with any type of wound and during catheter care. He/she should wash or sanitize hands before starting wound care, after touching soiled linens, with glove changes, and when finishing wound care or if there is a hole in a glove. He/she should change gloves when removing an old dressing, when the gloves are severely soiled, if there is a tear in the glove, and before putting on a new dressing. If an item is in the floor, he/she should clean it before giving it to the resident and he/she should clean scissors after use.<br><br>2. Observation on 09/26/25 at 9:10 A.M of wound care for Resident #56 showed:<br><br>- RN B and the Assistant Director of Nursing (ADON) donned gowns, washed hands, and donned gloves upon entry to the resident's room;<br><br>- RN B placed all supplies, except scissors and tape, on a paper plate and placed on the bed;<br><br>- RN B placed the scissors and tape on the bed with no barrier;<br><br>- ADON held Resident #56's leg in position;<br><br>- RN B picked up the scissors from the mattress and cut the dressing off the resident's right foot;<br><br>- RN B placed the scissors back on the resident's bed;<br><br>- While wearing the same gloves, RN B obtained wound cleanser-soaked gauze from a cup and cleaned the wound;<br><br>- While wearing the same gloves, RN B placed xeroform (topical wound dressing used to promote healing) and a gauze pad onto the wound, and wrapped the resident's foot and lower leg with gauze;<br><br>- While wearing the same gloves, RN B picked the tape up from the bed and placed a piece on the gauze;<br><br>- While wearing the same gloves, RN B reached under his/her gown into a pocket, obtained a marker, and initialed the tape;<br><br>- While wearing the same gloves, RN B wrapped the area with an ace wrap (a gentle compression bandage);<br><br>- The ADON lowered the resident's leg and placed a protective boot onto his/her left foot;<br><br>- The ADON removed gown and gloves, and washed hands;<br><br>- RN B threw trash away, then placed scissors and marker on the counter next to the sink;<br><br>- RN B removed gown and gloves, and washed hands;<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - RN B picked scissors and marker up from the counter and placed into his/her pocket without cleaning.<br><br>During an interview on 09/26/25 at 9:20 A.M., RN B said he/she had forgot to bring in a pad to put down as a barrier and should have cleaned the scissors before putting them in a pocket. Normally, they would have been cleaned with an alcohol wipe, soap and water, or a special spray.<br><br>During an interview on 09/26/25 at 1:40 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to wear appropriate PPE for EBP, a barrier to be used for supplies during wound care, staff to wash their hands after picking something up off the floor and before starting wound care, gloves to be changed from a dirty to clean task, and for hands to be washed or sanitized in between glove changes. They would expect markers and scissors to be sanitized after use. |