

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 345 Manor Road Mars Hill, NC 28754	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to discard food with signs of spoilage and remove expired food items in 1 of 1 walk-in cooler; maintain a clean and sanitary ice machine for 1 of 1 ice machine; date an opened food item in 1 of 1 dry storage room; and label and date opened food items for 1 of 1 kitchen. These practices had the potential to affect food served to residents. Findings included: a. An initial observation of the kitchen on 02/08/26 (Sunday) at 9:27 AM made without staff present revealed the following: - an undated bin of sugar- an undated bin of flour- an undated bin of cornmeal. b. An observation of the ice machine on 02/08/26 at 9:31 AM revealed pink and brown substances scattered across the entire baffle (white plastic piece of the machine that helps manage ice flow) of the machine. c. An observation of the dry storage room on 02/08/26 at 9:34 AM revealed an opened and undated bag containing five submarine sandwich rolls. d. An observation of the walk-in cooler on 02/08/26 at 9:37 AM revealed the following:- a cart with a bin of yogurt that contained seven four-ounce containers of assorted flavors of yogurt with a use-by date of 01/29/26- a box of eight heads of lettuce with brown discoloration- twelve four-ounce containers of assorted flavors of yogurt with a use-by date of 01/29/26 sitting on a shelf. An interview with the Dietary Manager on 02/08/26 at 2:16 PM revealed first and second shift cooks were responsible for ensuring all food was labeled and dated. She stated dish aides were responsible for checking use-by dates on yogurt and discarding them on or before the use-by date. The Dietary Manager stated she asked staff on second shift (she was unable to recall which staff members) to discard the lettuce on 02/06/26, but it should have been used or discarded before showing signs of spoilage. A follow-up interview with the Dietary Manager on 02/08/26 at 2:37 PM revealed Maintenance was responsible for cleaning the inside of the ice machine, but she would expect the ice machine to be clean. An interview with the Administrator on 02/10/26 at 1:42 PM revealed she expected all opened food to be labeled and dated and expired food or food with signs of spoilage should be discarded. The Administrator stated the dietary department was responsible for cleaning the ice machine and maintenance was responsible for cleaning the ice machine filter. A follow-up interview with the Administrator on 02/11/26 at 12:39 PM revealed she felt the expired and undated food were a result of the dietary staff feeling overwhelmed due to the recent ice storm because some of the staff had to stay in the facility during the bad weather.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345206
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