STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A404	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-MADISON INN	3550 HIGHWAY 468 WEST PO BOX 207 BLGS 28 &34 WHITFIELD, MS 39193

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F 000	INITIAL COMMENTS Amended on 03/11/20 to correct the number of licensed beds from 85 to 79. The State Agency (SA) conducted an annual recertification survey from 01/21/2020 to 01/23/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited deficiencies at F656, F693, and F880. At the time of the survey, the census was 65, and the facility held a license for 79 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/4/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/28/2020

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.

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow comprehensive care plan related to Percutaneous Endoscopic Gastrostomy (PEG) tube care for one (1) of five (5) PEG tube care plans reviewed, Resident #49. Findings include: A review the facility's "Nursing Documentation" policy, dated December 2016, revealed: "It is the professional responsibility of all licensed nurses to provide an accurate, in-depth clinical record of care for assigned residents. Documentation to meet this criteria included the care plan. A review of Resident #49's comprehensive care plan, revealed a problem to address the risk of	F 656	A. How the corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice; Resident #49 was assessed by the Director of Nurses on 1/22/2020 and was found to have no negative outcomes from the certified nursing assistant, (CNA) placing the head of the bed flat during incontinent care. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident's individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off.	

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F 656	Continued From page 2 aspiration related to the use of the feeding tube, onset date of 04/18/2016, and a target date of 04/02/2020. Approaches included to elevate head of bed (HOB) 30-45 degrees at all times. An observation of Resident #49's incontinent care, on 01/22/2020 at 2:29 PM, revealed Certified Nursing Assistant (CNA) #1 placed the HOB in a flat lying position for Resident #49's care. CNA #1 and CNA #2, who was assisting with incontinent care, failed to notify the nursing staff to stop the feeding pump, which had Diabetic Source running at 70 cubic centimeters (cc) per hour (cc/hr). CNA #1 placed Resident #49's HOB back in an upright position, after performing incontinent care. During an interview, on 01/22/2020 at 2:50 PM, CNA #1 and CNA #2 stated they had completed yearly competency checks which included incontinent care. Both CNAs stated they were not to touch the feeding pump, so they did not turn it off. CNA #1 further stated she was taught not to let the HOB down completely, but could provide care. CNA #1 confirmed she placed Resident #49's HOB in a flat position during incontinent care. An interview on 01/23/2020 at 1:33 PM, with the Director of Nursing (DON), revealed the facility's policy was for staff to notify the nurse to turn off the feeding pump during care to decrease the risk of aspiration. The DON stated both CNAs had received training related to the care of residents. The facility failed to provide a policy related to PEG tube care. During an interview, on 1/23/2020 at 2:55 PM,	F 656	B. Identification of other residents having the potential to be affected was accomplished by the same deficient practice; The facility has determined by the census on 1/23/2020 that eleven residents with Percutaneous Endoscopic Gastrostomy, (PEG) tubes have the potential to be affected by the deficient practice. C. Measures/systemic changes made to ensure that the deficient practice will not recur; The nursing staff that includes, (licensed practical nurses, registered nurses and certified nursing aides) was in-serviced/educated on the facility'□s policy and procedure for Percutaneous Endoscopic Gastrostomy tube care 01/23/2020 by the Director of Nurses (DON). The nursing staff was in-serviced/educated on the facility□s Care Plan Policy and procedure on 1/23/2020 by the DON. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident'□s individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off. All certified nursing assistants were in-serviced on the facility'□s Perineal Care policy on 01/23/2020 by the DON. In-service training included observation of each certified nursing assistant performing the procedure on residents	

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F 656	Continued From page 3 Registered Nurse (RN) #2, Minimum Data Set (MDS) Nurse, stated the expectation was for staff to follow the care plan according to the assessment.	F 656	with PEG tubes beginning 01/23/2020 until 02/22/2020. A Validation Checklist was completed on 2/22/2020 for each individual observed to determine if the certified nursing assistants were performing the procedure correctly by having the nurse turn the pump off prior to incontinent care. Findings were reviewed with each certified nursing assistant. D. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. This POC is integrated in the QA system. Care plans in accordance with the care plan review schedule will be reviewed weekly starting 1/26/2020 with the nursing staff by the Minimum Data Set nurse and Director of Nurses. The DON, or Registered nurse starting 1/26/2020 will complete weekly Validation Checklists of certified nursing assistants performing perineal care on residents with Peg tubes to ensure the feeding pump is turned off by a nurse and the head of bed is lowered prior to incontinent care weekly for four (4) consecutive weeks then monthly for two (2) months. Findings of this audit will be discussed and monitored by the Nursing Home Administrator, (NHA.) The NHA will report	

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F 656	Continued From page 4	F 656	findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month, should systemic changes not be effective, the QAPI committee will investigate and determine further action(s) to be implemented.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to prevent the risk of aspiration for a resident with a Percutaneous	F 693	A. How the corrective action(s) will be accomplished for those resident found to have been affected by the deficient	3/4/20

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F 693	Continued From page 5 Endoscopic Gastrostomy (PEG) tube, as evidenced by, the Certified Nursing Assistant (CNA) placing Resident #49's head of bed (HOB) flat, without notifying licensed nurse to hold/stop a continuous feeding pump, during incontinent care, for one (1) of five (5) care observations for residents with PEG tubes. Findings include: Review of the Perry and Potter Nursing Skills and Procedures - Eighth Edition, copyright 2015, revealed: Enteral Nutrition via a Gastrostomy or Jejunostomy Tube - Elevate the head of bed to a minimum of 30 degrees (preferably 45 degrees). Rationale - Elevated head helps prevent pulmonary aspiration. A review of Resident #49's revised physician orders, dated 11/18/2019, revealed an order for Diabetic Source at 70 cubic centimeters per hour (cc/hr) with 30 cc/hr water flush. Review of Resident #49's comprehensive care plan revealed a problem to address the risk of aspiration related to the use of the feeding tube, with an onset date of 0418/2015, and target date of 04/02/2020. Approaches included to elevate the HOB 30-45 degrees at all times. An observation of Resident #49's incontinent care, on 01/22/2020 at 2:29 PM, revealed Certified Nursing Assistant (CNA) #1 lowered the head of the bed (HOB) to flat position. CNA #1 and CNA #2 failed to notify the nursing staff to stop the feeding pump before or during incontinent care. The pump was noted to be infusing Diabetic Source at 70 cc/hour. CNA #1 placed Resident #49's HOB back after performing	F 693	practice; Resident #49 was assessed by the Director of Nurses on 1/22/2020 and was found to have no negative outcomes from the certified nursing assistant, (CNA) placing the head of the bed flat during incontinent care. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident's individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off. B. Identification of other residents having the potential to be affected was accomplished by the same deficient practice; The facility has determined by the census on 1/23/2020 that eleven residents with Percutaneous Endoscopic Gastrostomy, (PEG) tubes have the potential to be affected by the deficient practice. C. Measures/systemic changes made to ensure that the deficient practice will not recur; The nursing staff that includes, (licensed practical nurses, registered nurses and certified nursing aides) was in-serviced/educated on the facility'□s policy and procedure for Percutaneous Endoscopic Gastrostomy tube care 01/23/2020 by the Director of Nurses (DON). The nursing staff was	

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F 693	Continued From page 6 incontinent. During an interview, on 01/22/2020 at 2:50 PM, CNA #1 and CNA #2 stated they had completed yearly competency checks, which included incontinent care. The CNA revealed they were not to touch the feeding pump, so they didn't turn it off. CNA #1 stated she was taught not to let the HOB down completely, but could provide care. CNA #1 confirmed she did let Resident #49's HOB down, while the feeding pump was running, during the resident's incontinent care. An interview on 01/23/2020 at 1:33 PM, with the Director of Nursing (DON), revealed she stated, the facility's policy was for staff to notify the nurse, to turn off the tube feeding during care, to decrease the risk of aspiration. The DON revealed both CNAs had received training related to caring for residents. The facility did not provide a copy of the training records for CNA #1 or CNA #2. The facility failed to provide of a policy related Peg Tube care and procedures. A review of the facility's "Identification and Summary Sheet" for Resident #49, revealed the facility admitted the resident on 04/18/2016 with diagnoses which included of Dysphagia - Peg Tube.	F 693	in-serviced/educated on the facility□s Care Plan Policy and procedure on 1/23/2020 by the DON. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident'□s individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off. All certified nursing assistants were in-serviced on the facility'□s Perineal Care policy on 01/23/2020 by the DON. In-service training included observation of each certified nursing assistant performing the procedure on residents with PEG tubes beginning 01/23/2020 until 02/22/2020. A Validation Checklist was completed on 2/22/2020 for each individual observed to determine if the certified nursing assistants were performing the procedure correctly by having the nurse turn the pump off prior to incontinent care. Findings were reviewed with each certified nursing assistant. D. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. This plan of correction is integrated in the Quality Assurance system. Care plans in accordance with the care plan review schedule will be reviewed	

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F 693	Continued From page 7	F 693	weekly starting 1/26/2020 with the nursing staff by the Minimum Data Set nurse and Director of Nurses. The DON, or Registered nurse starting 1/26/2020 will complete weekly Validation Checklists of certified nursing assistants performing perineal care on residents with Peg tubes to ensure the feeding pump is turned off by a nurse and the head of bed is lowered prior to incontinent care weekly for four (4) consecutive weeks then monthly for two (2) months. Findings of this audit will be discussed and monitored by the Nursing Home Administrator, (NHA.) The NHA will report findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month, should systemic changes not be effective,the QAPI committee will investigate and determine further action(s) to be implemented.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		3/4/20

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F 880	Continued From page 8 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 9 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the possible spread of infection, during Percutaneous Endoscopic Gastrostomy (PEG) site care, as evidenced by placing soiled items on Resident #3's bed and floor, without the use of a biohazard bag, for one (1) of five (5) resident care observations. Findings include: Review of the facility's "Skin/Wound Care" policy, dated March 2014, revealed: Treatment of Wounds, the nurse will discard soiled dressings and gloves in biohazard bag. Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/17/2020 revealed, Section K (Nutritional Status) was coded to indicate the resident had a feeding tube. During an observation of Resident #3's PEG site	F 880	A. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #3 was assessed by the Director of Nurses on 1/23/2020 and was found to have no negative outcomes from Nurse #1 placing the soiled dressing from the stoma site on resident #3'□s bed. The nurse identified (Nurse #1) was immediately in-serviced on 1/23/2020 by the Director of Nurses (DON) on the proper procedures for wound care to Percutaneous Endoscopic Gastrostomy (PEG) site and the Infection Control Policy and Procedure. B. Identification of other residents having the potential to be affected was accomplished by: The facility has determined on 1/23/2020 by the census that eleven residents requiring PEG site wound care have the potential to be affected. C. Actions taken/systems put into place	

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F 880	Continued From page 10 care, on 01/23/2020 at 10:04 AM, Registered Nurse (RN) #1 removed the soiled dressing from the stoma site, and placed the dressing inside her soiled gloves, and laid them on the resident's bed. RN #1 stated she "forgot the red bag" for the garbage. After completing the care, RN #1 picked up the soiled dressing and gloves from the bed, placed them in a regular garbage bag. RN #1 then placed the regular garbage bag on the floor by the sink. She washed her hands, left the room to retrieve a red biohazard bag. When RN #1 returned to the resident's room, she placed the regular garbage bag, inside of the red biohazard bag, and then placed the red biohazard bag on the floor, while she washed her hands. RN #1 never changed Resident #3's bed sheet, after providing the care. During an interview, on 01/23/2020 at 10:27 AM, RN #1 confirmed she placed the dirty items on Resident #3's bed and on the resident's floor. RN #1 revealed the issue with placing the dirty gloves and dressing on the bed and floor could cause the spread of infection. RN #1 stated she didn't know what to do with the bag while she was washing her hands. An interview with the Director of Nursing (DON), on 01/23/2020 at 1:28 PM, revealed, the facility's policy was to use the biohazard bag for disposal of waste materials. The DON revealed RN #1 was was trained on the care of PEG tube sites and discarding of waste materials. The facility did not provide a copy of RN #1's training records related to PEG site care. A review of the facility's "Identification and Summary Sheet" revealed, Resident #3 was	F 880	to reduce the risk of future occurrence include: All licensed nursing staff was in-serviced on 01/23/2020 and 02/21/2020 by the Director of Nurses on the facility□s Wound Care and Infection Control policy procedure. In-service training included observation of each nurse performing wound care to a PEG site. A Validation Checklist was completed between 1/23/2020 and 02/21/2020 by the Director of Nurses for each nurse to determine if the nurse was performing the procedure correctly and disposing soiled dressings in a biohazard bag. Findings were reviewed with each nurse. D. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or Head Nurse, beginning 1/26/2020 will complete four (4) Validation Checklists of nurses performing PEG care weekly for (4) four weeks the monthly for (2) two months to ensure nurses are performing the procedure in accordance with our facility□'s PEG tube care and Infection Control policy and procedure, the resident□s physician order and care plan. Findings of this audit will be discussed with and monitored by the Nursing Home Administrator,(NHA) The NHA will report findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month, should systemic changes not be effective, the QAPI committee will investigate and determine further action(s) to be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A404	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-MADISON INN	3550 HIGHWAY 468 WEST PO BOX 207 BLGS 28 &34 WHITFIELD, MS 39193

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F 880	Continued From page 11 admitted by the facility on 07/02/2012, with diagnoses which included Dysphagia.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A404	A. BUILDING **01 - BUILDING 28 0102** B. WING _____	**01/20/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/12/2020

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.

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	25A404	A. BUILDING **02 - BUILDING 34 0202** B. WING _____	**01/20/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		3/11/20

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	25A404	A. BUILDING **02 - BUILDING 34 0202** B. WING _____	**01/20/2020**

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K 363	Continued From page 1 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 sections 19.3.6.3.5 and 19.3.6.3.13. The deficient practice affected two (2) of four (4) smoke compartments and 18 of 36 residents in the facility on day of survey. Findings include: On 1/24/2020 at 8:35 AM, observation revealed chairs propping open and obstructing the doors of the Dining Room on the 1st Floor and the Recreation Room on the 2nd Floor of Building 34 of the facility. The Dining Room and the Recreation Room were incapable of resisting the passage of smoke throughout the facility.	K 363	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 1/24/2020, upon notification of the deficient practice, the Coordinator of Unit Operations (CUO) removed the propped items from the doors and closed the doors. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? On 1/24/2020, the Coordinator of Unit Operations (CUO) and Director of Nursing (DON) reviewed the census and identified that 36 of 36 residents had the potential to be affected, only 18 of 36 residents were affected. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? On 1/24/2020, the Coordinator of Unit Operations (CUO) in-serviced the Recreational staff and Pantry staff on the	

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	25A404	A. BUILDING **02 - BUILDING 34 0202** B. WING _____	**01/20/2020**

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K 363	Continued From page 2	K 363	importance of keeping the doors to the dining room and recreational room closed and not using items to prop doors opened nor restrict doors from closing. Beginning 1/24/2020, the CUO began in-servicing all Madison Inn staff that included Licensed nurses, Registered nurses (RN), Minimum Data Set(MDS) nurse, Certified Nursing Assistants (CNA), Pantry staff, Housekeeping, Laundry, Medical Records, Recreational, and Behavior Health on the importance of not using items to prop doors open or restrict doors from closing. Beginning 1/24/2020, the CUO will use the Madison Inn Door Checklist to verify that the dining room and recreational room doors are closed and not propped open. The CUO will report any deficiencies to the Nursing Home Administrator(NHA)and corrected promptly by the CUO. Any staff found to be using items to prop open the doors will be re-educated by the CUO. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? Findings from the Madison Inn Door Checklist monitoring will be discussed with the Nursing Home Administration (NHA). The NHA will report findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) Committee each month, should systemic changes not be effective, the QAPI Committee will investigate and determine further action(s) to be implemented.	

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E 000	Initial Comments ********** Survey conducted on 01/20/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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