STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and two (2) Complaint Investigations (CI MS #27198 and CI MS #27119) at the facility from 1/14/25 through 1/16/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies at F 578, F 641, F 656, F 677, F 761, F 810, F 812, and F 880. The SA found the facility not to be in compliance related to CI MS #27198 and CI MS #27119 regarding Activities of Daily Living and implementing a care plan and cited F 656 and F 677. The facility had a census of 56 at the time of the survey and was licensed for 60 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		2/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2025

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to honor resident's rights to make health care decisions for three (3) of 24 residents reviewed for advanced directives. Resident #10, #36, and #48 Findings Include: Record review of the facility policy titled "Do Not Resuscitate No Code Status Policy" dated 2/2024 revealed, "It is the policy of this facility to inform residents of the right to choose to have CPR (cardiopulmonary resuscitation) or no CPR to be performed at such time of imminent death. ...	F 578	"On 1/16/2025, Residents #10, #36, and #48 reviewed, selected, and signed their advanced directives, code status forms. "All competent Residents have the potential to be affected by this deficient practice "In-services were conducted by the administrator on 1/16/2025 with the director of nursing, social services director, and medical records for all competent residents to complete their own code status form upon admitting into the facility. Effective 1/16/2025, the	

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F 578	Continued From page 2 The code status form will be completed at the time of admission." Resident #10 Record review of Resident #10's "Order Summary Report" revealed, DNR (Do Not Resuscitate): Need for death with dignity related to choice of code status DNR per family/Resident Representative (RR) request. Record review of the "Code Status" form for Resident #10 revealed a family member signed the form dated 10/16/24, with no signature from the resident. An interview with Resident #10 on 1/15/25 at 10:35 AM revealed he can make his own decisions and sign his paperwork. He stated that when he was admitted to the facility, he did not recall anyone asking him whether he wanted to be a full code or DNR and admitted that he did not sign any paperwork on it. He stated that it should be his choice since "I can make my own decisions." Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/2024 for Resident #10 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/16/2024 with diagnoses that included Chronic Systolic (Congestive) Heart Failure, and Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation.	F 578	administrator and social services director is reviewing all Resident charts to ensure each competent patient has signed their own advance directive code status form. Effective 1/16/2025, all competent Residents will have the right to review, select, and sign their own advance directive code status form. This form will be reviewed, completed, and signed by all competent Residents upon admitting into the facility. "Beginning 1/20/2025, Social Service Director and Medical Record personnel will perform weekly audits on all Residents charts to ensure each competent resident has completed their own code status form times three months. Observations will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 578	Continued From page 3	F 578		

Resident #36

Record review of Resident #36's "Order Summary Report" revealed full code related to family/Resident Representative choice of code status. Resident is a full code.

Record review of the "Code Status" form for Resident #36 revealed a family member signed the form dated 10/31/24, with no signature from the resident.

An interview with Resident #36 on 11/15/25 at 11:45 AM, revealed when she was admitted to the facility, she did not sign her code status form, and no one spoke to her about it. She stated that she can still make her own decisions, and even though she has Parkinson's, and it may take her a little longer, she can still sign.

Record review of Resident #36's MDS with an ARD of 11/06/2024 revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #36 on 10/31/2024 with diagnoses that included Hypoglycemia, Unspecified, and Parkinson's Disease without Dyskinesia.

Resident #48

Record review of Resident #48's "Order Summary Report" revealed, full code related to family/Resident Representative choice of code status. Resident is a full code.

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F 578	Continued From page 4	F 578		

Record review of the "Code Status" form for Resident #48 revealed a family member signed the form dated 11/19/24, with no signature from the resident.

In an interview on 1/15/25 at 8:50 AM, Resident #48 revealed that she did not sign her Advance Directives when admitted to the facility. She stated that no one at the facility had spoken with her about her code status.

Record review of the MDS with an ARD of 11/25/2024 for Resident #48 revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #48 on 11/19/2024 with diagnoses that included Multiple Fractures of Pelvis without Disruption of Pelvic Ring, and Chronic Kidney Disease, Stage 3.

An interview with the Social Services Director on 1/15/25 at 1:15 PM, revealed that when a resident was admitted to the facility, she had been discussing their code status with the family representative or power of attorney (POA) and had not been going over it with the resident. She confirmed that Residents #10, #36, and #48 did not sign their code status form, and they should have because it was their right.

During an interview on 1/15/25 at 1:40 PM, the Administrator confirmed that the residents who were competent and able to sign their Advance Directive should be allowed to do so, and we should ensure that their wishes were honored.

In an interview on 1/16/25 at 10:38 AM, the

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F 578	Continued From page 5 Director of Nurses (DON) confirmed that Residents #10, #36, and #48 were cognitive and able to make their own decisions and should have had the opportunity to decide what their end-of-life wishes were.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code section A of the Minimum Data Set (MDS) for a resident with a serious mental illness for one (1) of 16 MDS reviewed. Resident #16 Findings Include: The facility provided a statement on letterhead dated 1/15/25 that read, "It is the policy of "Proper Name of the Facility" to follow the RAI (Resident Assessment Instrument) manual for completion and accuracy of the MDS (Minimum Data Set) assessments." Record review of Resident #16's Preadmission Screening and Resident Review (PASRR) "Summary of Findings Report" dated 6/14/2017, revealed under, "Mental Health ... The individual meets criteria for having a diagnosis of mental illness as defined by PASRR." Also revealed under, "Axis I primary: Schizophrenia" was listed as the diagnosis. Record review of Resident #16's Annual MDS	F 641	"Effective 1/15/2025, Resident #16 Minimum Data Set (MDS) assessment was modified for the resident to have a serious mental illness and/or intellectual disability or a related condition by the MDS nurse. "All Residents with a serious mental illness an/or intellectual disability requiring a level 2 Pre Admission Screening and Resident Review have the potential to be affected by this deficient practice. "Inservice conducted with MDS nurses on 1/15/2025 by administrator for all Residents with a Level 2 Preadmission Screening and Resident Review to have selected yes for section A1500 if resident has a serious mental illness and/or intellectual disability or a related condition. This is to be done accurately on the admission MDS assessment and annual MDS assessment. Effective 1/15/2025, the admission and annual MDS assessments will be completed accurately	2/14/25

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F 641	Continued From page 6 with an Assessment Reference Data (ARD) of 4/01/24 revealed, under section A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No" was answered. An interview with the MDS Nurse on 1/15/25 at 2:35 PM, confirmed Section A of Resident #16's MDS was coded inaccurately. She confirmed that the resident had a serious mental illness, and the assessment should be accurate to develop a complete plan of care. An interview with the Director of Nursing (DON) on 1/15/25 at 2:52 PM revealed, his expectations were for the MDS assessments to accurately reflect each resident's status and plan of care. Record review of the "Admission Record" revealed the facility admitted Resident #16 on 5/03/17 with medical diagnoses that included Schizophrenia and Unspecified Psychosis.	F 641	by the MDS nurse. Audit conducted on 1/20/2025 by director of nursing and MDS nurses on all Residents to ensure section A1500 is accurate. "Effective 1/20/2025, audits will be conducted weekly by director of nursing or MDS nurses for all admission MDS assessments and annual MDS assessments to ensure accuracy of section A1500 times three months. Observations will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		2/14/25

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F 656	Continued From page 7 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for personal hygiene.(Resident #1, #2, #7) and adaptive equipment with meals (Resident #2) for	F 656	"Resident #1 received oral care, hygiene care, and facial hair was removed on 1/15/2025 by assigned CNA. Resident #7 received nail care on 1/15/2025 by having her nails trimmed and cleaned by	

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F 656	Continued From page 8 three (3) of 16 care plans reviewed. Residents #1, # 2, #7 Findings Include: Review of the facility policy titled, "Following the Care Plan Policy" unrevised, revealed under, "Policy: It is the Policy of this facility to follow a written and approved care plan for each resident." Resident #1 Record review of Resident #1's ADL (activities of daily living) "Care Plan" revealed under, "Focus: The resident has an ADL self-care performance deficit r/t (related to) Dementia". Also revealed under, "Intervention/Task: Personal hygiene/Oral care: The resident requires x (times) 1 (one) staff participation with personal hygiene ..." An observation on 1/14/25 at 9:20 AM revealed Resident #1 lying in bed with long facial hair on her chin, which was approximately three to four inches long. On 1/16/25 at 9:10 AM, an interview with the Director of Nursing (DON) confirmed the ADL care plan was not followed for Resident #1. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/03/2017 with medical diagnoses that included Major Depressive Disorder and Muscle Weakness. Resident #7 Record review of Resident #7's ADL "Care Plan"	F 656	assigned CNA. Resident #2 received hygiene and oral care on 1/15/2025 by assigned CNA. Effective 1/15/2025, Resident #2 is receiving adaptive equipment for all meals based on physician orders. "All Residents have the potential to be affected by this deficient practice. "Effective 1/16/2025, all care plans for Activities of Daily Living and usage of adaptive equipment are being followed accurately. Inservice conducted on 1/16/2025 by administrator to nursing staff for care plans to be followed for activities of daily living. Inservice conducted by administrator on 1/16/2025 to nursing and dietary staff on providing adaptive equipment to be used for meals. ADL care from care plans are being audited every shift by the assigned licensed practical nurse and nurse supervisor. Clinical supervisors are conducting weekly rounds on all Residents to evaluate ADL care and that care plans are being followed. These rounds are being submitted weekly to the administrator or director of nursing. "Effective 1/16/2025, the administrator and director of nursing will each assess three different patients weekly to monitor that care plans are being followed towards activities of daily living care times three months. Effective 1/16/2025, director of nursing or administrator will conduct weekly audits to ensure that adaptive equipment is being used for all meals for those with orders times three months. The	

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F 656	Continued From page 9 revealed under, "Focus: The resident has an ADL self-care performance deficit r/t Rhabdomyolysis". Also revealed under, "Intervention/Task: Check nail length and trim and clean on bath day and as necessary." An observation of Resident #7 on 1/14/25 at 9:00 AM, revealed she was lying in bed and had long fingernails approximately one-half (1/2) to three-fourths (3/4) inches in length on both hands. On 1/15/25 at 1:20 PM, an observation and interview with CNA #1 confirmed Resident #7's fingernails were too long. On 1/16/25 at 9:10 AM, an interview with the DON confirmed the ADL care plan was not followed for Resident #7. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 12/20/24 with a medical diagnosis of Rhabdomyolysis. Resident #2 Record review of Resident #2's ADL "Care Plan" revealed under, "Focus: The resident has an ADL self-care performance deficit r/t weakness, osteoarthritis". Also revealed under, "Interventions: Personal hygiene/Oral care: The resident requires x (times) 1 staff participation with personal hygiene and oral care." On 1/14/25 at 8:09 AM, an observation of Resident #2 revealed that she was sitting in her wheelchair in her room. As the resident was trying to communicate, a thick white substance was	F 656	weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 656	Continued From page 10	F 656		

observed on her upper and lower teeth and on her gums.

An observation and interview with the DON on 1/15/25 at 3:22 PM confirmed oral hygiene was not done and described Resident #2's teeth as "plaque buildup and food particles."

Resident #2

Record review of Resident #2's nutritional "Care Plan" revealed under, "Focus: The resident at risk for potential nutritional problems related to diet restrictions ..." Also revealed under, "Interventions/Task: Resident to have divided plate with meal, date initiated 9/15/22 and "Resident to have sippy cup with meals, date initiated 9/22/23 ...".

An observation of Resident #2's lunch meal on 1/14/25 at 11:55 AM revealed that she was served on a regular plate with a glass of tea and water in a goblet style. An observation of the resident's meal ticket at this time revealed, "Divided plate, sippy cup." and the resident did not have these available.

An interview with the DON on 1/14/25 at 12:01 PM, confirmed Resident #2 did not have the adaptive equipment that was listed on her meal ticket.

An interview with the MDS Nurse on 1/16/25 at 8:16 AM revealed the purpose of the care plan was for the staff to know what care to provide for the residents. She confirmed Resident #2's care plan was not followed for oral hygiene and adaptive equipment.

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F 656	Continued From page 11 Record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide nail care, oral care and facial hair removal for resident's requiring assistance with activities of daily living (ADLs) for three (3) of 16 sampled residents. Resident #1, #2, and #7 Findings Include: Record review of the facility policy, "ADL Care Policy" undated, revealed, "It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis ..." Resident #1 An observation and interview on 1/14/25 at 9:20 AM revealed, Resident #1 with facial hair on her chin that was approximately three (3) to four (4) inches long. An interview with the resident revealed that she did not like facial hair and stated, "I want them gone."	F 677	"Resident #1 had their facial hair removed and nail care provided on 1/15/2025 by the assigned CNA. Resident #7 had their nails trimmed and cleaned on 1/15/2025 by the assigned CNA. Resident #2 Received oral hygiene care on on 1/15/2025 by the assigned CNA. "All Residents have the potential to be affected by this deficient practice. "Effective 1/16/2025, activities of daily living hygiene, oral care, hair care, and nail care is being completed on a daily basis by all shifts. Inservice conducted on 1/16/2025 by administrator for nursing staff to educate the importance of activities of daily living care towards all residents on a daily basis. As of 1/20/2025 clinical supervisors are evaluating all Residents weekly to ensure ADL care is being provided for. Any issues notated will immediately be addressed by assigned licensed practical nurse and assigned certified nurse aide.	2/14/25

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F 677	Continued From page 12 An observation and interview on 1/15/25 at 1:27 PM, with Certified Nursing Assistant (CNA) #1 revealed facial hair and fingernails should be taken care of during bath time or anytime it was noticed. She confirmed that Resident #1 had long hair on her chin and admitted it should have already been taken care of. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/03/2017 with medical diagnoses that included Major Depressive Disorder and Muscle Weakness. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/24, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #7 On 1/14/25 at 9:00 AM, an observation and interview with Resident #7 revealed she had fingernails approximately one-half (1/2) to three-fourths (3/4) inches in length past the tips of the fingers. She admitted that she had never had fingernails this long before, and stated, "I keep them very short; I feel like they are like claws now." The resident revealed she had been at the facility since December, and no one had offered to clip her nails. An observation and interview on 1/15/25 at 1:20 PM of Resident #7 with CNA #1 revealed that fingernails should be checked every day, cleaned and clipped when needed. She confirmed	F 677	"Effective 1/16/2025, the administrator and director of nursing will each assess 3 different patients weekly to ensure activities of daily living care is being completed on residents times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 677	Continued From page 13	F 677		

Resident #7's fingernails were long and Resident #7 stated to CNA #1, "I have never had my nails this long before and I want them cut." CNA #1 stated that with the resident's fingernails that long she could scratch herself and cause skin tears or the spread of bacteria.

On 1/16/25 at 8:30 AM, an interview with Registered Nurse (RN) Supervisor revealed that the nurses should be checking behind the aides to make sure the resident needs were taken care of. She revealed she was not aware Resident #7 had long fingernails and confirmed that nail care should be included in their personal hygiene task.

On 1/16/25 at 9:10 AM, an interview with the Director of Nursing (DON) confirmed that the nurses and the aide supervisor should be overseeing the completion of ADL care. He revealed that anyone who noticed a need with a resident should take care of the problem or tell someone who could.

Record review of the "Admission Record" revealed the facility admitted Resident #7 on 12/20/24 with a medical diagnosis of Rhabdomyolysis.

Record review of Resident #7's MDS with ARD of 11/26/24 revealed under Section C, a BIMS score of 10, which indicated the resident was moderately cognitively impaired.
Resident #2

An observation of Resident #2 on 1/14/25 at 8:09 AM revealed the resident was trying to talk and a thick white substance was observed on her upper and lower teeth and gums.

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F 677	Continued From page 14 An observation of Resident #2 on 1/15/25 at 8:06 AM revealed no change in the resident's teeth and gums. An observation and interview on 1/15/25 at 3:10 PM, with CNA #2 revealed she was assigned to Resident #2 today on day shift. She confirmed the resident had excess buildup on her teeth and that she did not brush the residents' teeth today. She explained that the resident was on the "get up" list and that the night shift should have done it. She admitted that she should have checked behind them to ensure it was done. An observation and interview with the DON on 1/15/25 at 3:22 PM described Resident #2's teeth as "plaque buildup and food particles." He revealed that the aides and nurses were responsible for oral care and brushing the resident's teeth. The DON stated that the resident could develop decay and cavities from not getting the appropriate oral care. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		2/14/25

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F 761	Continued From page 15 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and facility policy review, the facility failed to properly store medications, as evidenced by, medications left in a resident's room for one (1) of 16 sampled residents. Resident #41 Findings Include: Record review of the facility policy "Medication Storage" dated 01/2024, revealed "It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication cart and/or medication rooms according to the manufacturer's recommendation....." An observation on 1/14/25 at 11:00 AM and 2:00 PM revealed a one-ounce bottle of lubricant eye drops and a two-ounce tube of pain relief cream on the overbed table in Resident #41's room.	F 761	"Resident #41 had their eye drops and pain cream removed from the resident room and placed in the nurse cart on 1/15/2025 by assigned licensed practical nurse. "All Residents have the potential to be affected by this deficient practice. "Effective 1/16/2025, all resident medications are being stored appropriately on the nurses carts and med storage room. Inservice conducted with Nursing staff on 1/16/2025 by administrator to inform nursing staff of proper medication storage. on 1/17/2025, rounds conducted on all rooms by administrator, director of nursing, and staffing director to ensure medications were not being stored incorrectly in	

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F 761	Continued From page 16 An interview on 1/14/25 at 2:50 PM, with Resident #41 revealed he brought his eye drops and pain cream from home, and he applied them himself. He revealed that he used the eye drops every day and that he hardly ever used the pain cream. The resident explained he kept these items in his room so he could use them as needed. An observation and interview with Licensed Practical Nurse (LPN) #1 on 1/15/25 at 9:58 AM, confirmed Resident #41 had a bottle of lubricant eye drops and a tube of pain cream on his bedside table. She revealed the resident had not been assessed for self-administration and explained medications were not supposed to be in his room. LPN #1 agreed that leaving medications in a resident's rooms was a risk, and another resident could enter his room and take something they were not supposed to have. An interview on 1/15/25 at 10:40 AM, with the Director of Nursing (DON) confirmed that leaving medications in a resident's room should not happen. He revealed that some residents were used to self-administering medications at home before coming into the facility, and it was often hard for them to adjust. The DON stated that if a resident requested to self-administer their medications, then an assessment should have been done to ensure they were competent and knew how to use it. He revealed this one must have slipped through the cracks and explained that someone should have seen the medications in Resident #41's room and removed them. Record review of Resident #41's "Admission Record" revealed an admission date of 9/10/24, with medical diagnoses that included Unspecified Injury of Left Lower Leg, Muscle Weakness, and	F 761	Resident rooms. On 1/17/2025, the director of nursing audited all nursing carts and med storage room to ensure medications were being stored properly. "Effective 1/16/2025, weekly rounds are being conducted by the administrator and director of nursing to audit three Residents each to ensure medication is being properly stored times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 761	Continued From page 17 Need for Assistance with Personal Care. Record review of Resident #41's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24, revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide a resident with adaptive equipment during meals for one (1) of two (2) dining observations. Resident #2 Findings Include: Review of the facility policy titled "Assistive Feeding Devices" with a revision date of 6/14 revealed under, "Policy: Residents shall be provided assistive devices to maintain or improve their ability to eat independently." Also revealed under, "Procedure:... 4. The assistive devices are placed on the resident's tray at the time of meal service." An observation on 1/14/25 at 11:55 AM revealed Resident #2's lunch meal was served on a regular plate with a goblet glass of tea and water	F 810	"Effective 1/15/2025, Resident #2 is receiving a divided plate and cup with handles for all meals. Effective 1/16/2025 order and care plan revised for Resident #2 to receive a divided plate and cup with handles and straw for all meals and drinks by the Minimum Data Set (MDS) nurse. "All Residents requiring adaptive devices have the potential to be affected by this deficient practice. "Effective 1/16/2025, all Residents requiring adaptive devices for meal times are receiving them. Inservice conducted by administrator on 1/15/2025 with dietary staff to serve adaptive equipment for residents with orders for the usage of adaptive equipment. Dietary inventory audit conducted on 1/16/2025 by dietary	2/14/25

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F 810	Continued From page 18 with a meal ticket that read, "Divided plate, sippy cup." An interview with the Director of Nursing (DON) on 1/14/25 at 12:01 PM confirmed that Resident #2 did not have the adaptive equipment that the resident should have had. Record review of the "Order Details" for Resident #2 revealed an order dated 11/15/21, "Patient to have sippy cup at breakfast, lunch, and dinner with meal." A record review of the "Order Details" for Resident #2 revealed an order dated 11/19/21, " ... Divided plate with meals". An interview with Dietary Staff #2, on 1/15/25 at 8:10 AM confirmed when adaptive equipment was on a meal ticket, the dietary server should provide it during the tray preparation. She revealed the purpose of ensuring the adaptive equipment was available with the meal was to help the residents be more independent with feeding themselves. An interview with the DON on 1/15/25 at 8:20 AM confirmed that the purpose of the adaptive equipment was to assist the resident with feeding herself and confirmed it should be available with each meal. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.	F 810	manager to ensure facility has all adaptive equipment necessary to serve the Residents. Dietary audit conducted on 1/16/2025 by dietary manager to ensure Resident tickets have the proper adaptive equipment needs listed on all meal tickets. Inservice conducted with nursing staff on 1/16/2025 by administrator to check trays and meal tickets to ensure Residents that require adaptive devices are receiving them correctly. "Effective 1/16/2025, the Dietary manager is conducting weekly rounds to ensure that adaptive equipment is being served and provided as ordered and care plans state times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/14/25

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F 812	Continued From page 19 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review the facility failed to ensure items in the walk-in kitchen refrigerator were labeled and dated, discarded by the expiration date, and arranged in a manner to prevent possible cross-contamination for one (1) of three (3) kitchen tours Findings include: Review of the facility policy titled, "Labeling and Dating Inservice" revised 2/2023, revealed "All foods should be dated upon receipt before being stored. Food labels must include: The food item name, the date of preparation/receipt/removal from freezer, and the "use by" date. ...Leftovers must be labeled and dated with the date they are	F 812	"On 1/14/2025, the unlabeled, expired Yoplait yogurt and tropical fruit supreme was discarded from the facility by dietary manager. On 1/14/2025, the improperly stored and improperly labeled chicken salad, pimento cheese, liquid eggs, chopped ham, sausage and peppers, and boiled eggs were discarded from the facility by the dietary manager. On 1/14/2025, the improperly stored and improperly labeled chicken and pork were discarded from the facility by the dietary manager. "All Residents who receive meals from dietary have the potential to be affected by this deficient practice.	

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F 812	Continued From page 20 prepared and the "use by" date. Review of the facility policy titled, "Food Storage: Cold Foods" revealed, 5 ..."All foods will be stored, wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." An observation and interview on the initial tour of the kitchen with the Dietary Manager (DM) on 1/14/25 at 8:05 AM, revealed in the walk-in refrigerator two white opened containers with a manufacturer label of "Yoplait Vanilla Yogurt". The containers were not dated and had a manufacturer best-by date of Dec 24, 2024. An observation of a five-pound opened "Sysco Tropical Fruit Supreme" with no open date nor use-by date. The DM revealed she was unsure when it was opened. An observation of a five-pound white container of Wholesome Farm sour cream dated 12/17/24 with no use-by date, and a large clear plastic container dated 1/11 with no label or use-by date. The DM identified the food item as chicken salad. An unlabeled clear plastic container dated 1/7 with no use-by date, which the DM identified as pimento cheese, a 2-inch-deep rectangular metal pan unlabeled with a date of 1/14, with no use-by date, the DM identified as liquid eggs, a square clear container unlabeled with a date of 1/14, with no use-by date, the DM revealed that is chopped ham, a transparent plastic square container unlabeled with a date of 1/8 on one side and a date of 1/13 on the other side, the DM revealed they had this last night for supper and confirmed the food item was cooked sausage and peppers. She confirmed the date for the meal was last night but wasn't sure why they didn't change the date on the container. Observation revealed a small	F 812	"Effective 1/15/2025, all foods are correctly labeled, dated, and stored appropriately. Inservice conducted by administrator with all dietary staff on 1/15/2025 that all items need to be labeled and dated before being stored. Inservice also states once an item is opened, it must have a use by label of seven days after opening. Inservice conducted by administrator on 1/15/2025 on cross contamination and how to properly store separate items in separate containers. Inservice also states of any expired foods to be immediately removed from the facility. "Effective 1/15/2025, the dietary manager is conducting rounds twice a week to ensure all items are labeled appropriately, any expired items are being discarded from the facility, and that no cross contamination is occurring times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 812	Continued From page 21 square pan unlabeled and undated which the DM confirmed the food items were four boiled eggs in a clear liquid and revealed she wasn't sure how long they had been there. An observation of a rectangular metal tray on the bottom shelf of the refrigerator revealed a labeled gallon-sized bag of chicken in a liquid substance; the bag was undated, and in the same pan wrapped in cellophane was an unlabeled and undated food item the DM identified as pork loin . A liquid substance was noted on the bottom of the metal tray where both food items were placed. The DM revealed they were both undated and should not have been in the same container thawing because this could cause bacteria, and the residents could get sick. She confirmed that the food items in the refrigerator were not properly labeled and dated and that all foods should have dates for when they should be discarded. In an interview on 1/14/25 at 8:20 AM with the Dietary Aide revealed that when the food items come in, he puts the dates that they arrived, and then when they open them, they are supposed to put that date and then a use by date. He confirmed the items in the walk-in refrigerator were not correctly labeled. In an interview on 1/15/25 at 12:05 PM, the Administrator confirmed that it is the facility policy that all food items be properly labeled, dated when they arrive at the facility, when they are opened and discarded within the proper time to prevent any food-borne illnesses.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		2/14/25

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F 880	Continued From page 22 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 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 §483.71 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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F 880	Continued From page 23 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 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, and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) while providing resident care for two (2) of three (3) direct care observations. Resident #28 and Resident #49 Findings Include: Record review of the facility policy "Enhanced Barrier Precautions" with a revised date of 8/07/24, revealed under, "Policy Explanation and Compliance Guidelines:... 2. Initiation of Enhanced Barrier Precautions:... b. An order for	F 880	"Effective 1/16/2025, all nursing personnel are wearing enhanced barrier protective (EBP) gowns when performing peg care for resident #28. Effective 1/16/2025, all nursing personnel are wearing enhanced barrier protective gowns when administering foley catheter care to resident #49. "Any resident with enhanced barrier protective orders has the potential to be affected by this deficient practice.	

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F 880	Continued From page 24 enhanced barrier precautions will be obtained for residents with any of the following: Wounds ... and/or indwelling medical devices (...urinary catheters, feeding tubes ...) even if the resident is not known to be infected ..." Resident #28 An observation on 1/15/25 at 8:55 AM revealed Licensed Practical Nurse (LPN) #2 administered Resident #28's medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube without wearing a gown for EBP. He revealed that EBP were supposed to be utilized when providing care to residents who had Covid-19 or open wounds. He stated that he did not think they had to follow the precautions for residents with PEG tubes. LPN #2 agreed that EBP were put in place to protect the residents and the staff to prevent the spread of germs. Record review of Resident #28's Order Summary Report with active orders as of 1/16/25 revealed an order for EBP related to PEG every shift and medication orders for administration through the PEG Tube. Record review of Resident #28's "Admission Record" revealed an admission date of 4/29/24 with medical diagnoses that included Ventricular Fibrillation and Dysphagia. Resident #49 An observation on 1/15/25 at 10:50 AM revealed LPN #1 completed Resident #49's catheter care and changed the drainage bag without wearing a gown. LPN #1 revealed they (the staff) had to	F 880	"Effective 1/16/2025, all nursing personnel are abiding by infection control policies towards enhanced barrier precautions. As of 1/15/2025, Personal protective equipment (PPE) is readily located for all employees to use along with enhanced barrier protective guidelines. Inservice conducted on 1/16/2025 by administrator for all staff on infection control and enhanced barrier protection protocols and policies. "As of 1/20/2025, the infection preventionist nurse will conduct three observations weekly on staff to ensure employees are using personal protective equipment when performing care on residents under enhanced barrier precautions times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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F 880	Continued From page 25	F 880		

wear a gown if a resident had open wounds or something contagious like Covid-19. She stated that she was not aware that gowns had to be worn when providing catheter care.

An interview on 1/15/25 at 11:25 AM, with the Director of Nursing (DON) revealed EBP were to be used with any residents who had indwelling medical devices to protect the residents from infection. He revealed the staff had been in-serviced and knew they were supposed to wear gloves and gowns when they provided care to these residents.

Record review of Resident #49's "Admission Record" revealed an admission date of 12/09/24 with medical diagnoses that included Malignant Neoplasm of the Prostate and Chronic Kidney Disease.

Record review of Resident #49's Order Summary Report with active orders as of 1/16/25 revealed, "Resident to be placed on EBP related to Foley" and there was an order for catheter care every day related to Retention of Urine diagnosis.