STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD , MADISON, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation, Complaint 2965461 and Complaint (Incident) 2961832 at the facility on 4/13/26. Both were investigated related to misappropriation, medication storage and medication administration. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F602. The facility held a license for 60 beds, with a census of 59.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review, and staff and resident interviews, the facility failed to prevent the misappropriation of property, specifically scheduled medication, for one (1) of four (4) sampled residents, Resident #1. Findings Included: Record review of the facility's Abuse Policy and Procedure with Review/Revision Date 1/24/22 revealed, "Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment, neglect and or misappropriation of resident property…7. 'Misappropriation of resident property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings	F0602		

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 reverse for further 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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F0602 SS = D	Continued from page 1 or money without the resident's consent...". On 4/13/26 State Agency (SA) conducted an investigation for complaint 2965461 and facility reported Incident 2961832 at the facility related to misappropriation of medication, medication administration and medication storage. Record review of the Facility Investigation dated 3/23/26 revealed that on 3/19/26 it was discovered during shift change by LPN (Licensed Practical Nurse) #2 and LPN #3 that Resident #1's medication, Clonazepam, was tampered with two (2) tablets removed from their blister pack and replaced with two (2) unidentified tablets. The tampered with blister pack that contained the unidentified tablets was delivered to the former Director of Nurses (DON) who replaced the blister pack with the unidentified tablets taped inside back in the Narcotic Lock box in the Medication Cart. According to the facility's investigation, all three nurses that had access to the 100 Hall medication lock box submitted to drug tests and the facility was unable to determine how or when or by whom the blister pack had been tampered with and the blister pack that had been tampered with and the remaining tablets therein were destroyed on 3/20/26 and the medications were replaced. The Facility Investigation included a printed statement dated 3/23/26 and signed by LPN #2 confirmed that "the resident's medication card contained incorrect medications". Record review of the Controlled Drug Package Inventory log for the medication cart for the 100 Hall dated 3/14/26 through 3/20/26 revealed that on 3/20/26 one (1) package that contained thirteen (13) doses (tablets) of Clonazepam 2 mg (milligrams) that belonged to Resident #1 was removed from the 100 Hall Medication Cart Narcotics Locked Box. Record review of the Controlled Drug Record with delivery date 3/06/26 revealed Resident had forty-two (42) Clonazepam 2 milligram tablets, with description included as "This medicine is a white, round-shaped, scored tablet imprinted with a 2", delivered to the facility for Resident #1. According to the Record, tablet number 17 was administered to Resident #1 by LPN #1 and tablet number 16 was wasted on 3/20/26 by the Staff Development Nurse. Record review of the Drug Wastage Destruction Log for controlled Substances dated 2/04/24 through 3/20/26 revealed that on 3/20/26 there was one (1) "incorrect med" for Resident #1 was destroyed by the Staff Development Nurse.	F0602		

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F0602 SS = D	Continued from page 2 Record review of the Order Summary Report with active orders as of 4/13/26 for Resident #1 revealed she had a physician's order for Clonazepam 2 milligram tablet, one (1) tablet by mouth three (3) times a day related to essential tremor. During an interview the Administrator on 4/13/26 at 11:30 AM revealed the facility had investigated and reported to appropriate agencies the misappropriation of two (2) 2 milligram Clonazepam tablets belonging to Resident #1 on 3/23/26. He explained that on 3/19/26, LPN #2 and LPN #3 conducted narcotics accountability count for the locked narcotics box on the 100 Hall medication cart at approximately 7:00 AM during shift change, realized that Resident #1's blister pack of Clonazepam 2 milligram tablets had been tampered with as the foil back of tablets numbers 16 and 17 had been punctured, and it was determined that there were unidentified tablets in the blister package in the damaged blisters. He confirmed that all three (3) of the nurses that had access most recently to the narcotics locked box on the 100 Hall medication cart submitted to drug tests and that the facility could not determine when or by whom the blister pack had been tampered with. He confirmed that the resident had been assessed following the discovery and determined to have no adverse effects and she was her own resident representative and her primary healthcare provider was notified with no new orders notes. He stated that the facility investigation did not result in determination of who had damaged the package, taken the resident's prescribed, scheduled medication, or replaced the missing tablets with unidentified tablets. On 4/13/26 at 12:45 PM an interview and observation with Resident #1 revealed she had essential tremors and was prescribed Clonazepam for the tremors for approximately thirty (30) years. She stated she felt safe at the facility and that having not received one dose of her Clonazepam had not affected her to the best of her knowledge. She stated she had constant tremors with or without the Clonazepam. The resident was neat, clean, well-groomed, appropriately dressed and seated in her wheelchair with good posture and constant nodding of her head and shaking hands. She said that she appreciated the facility's addressing the incident in an appropriate manner and that she had not had any adverse reaction from the medication error. Record review of the Controlled Drug Record for Resident #1's Clonazepam 2 MG (milligram) tablets revealed that on 3/06/26 forty-two (42) tablets had been delivered to the facility from the pharmacy.	F0602		

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F0602 SS = D	Continued from page 3 Record review of the Controlled Drug Package Inventory sheet for the 100 Hall revealed that on 3/20/26 a blister pack that contained thirteen (13) tablets of Klonopin (clonazepam) 2 MG for Resident #1 was removed from the 100 Hall medication cart locked narcotics box. Record review of the Drug Wastage Destruction log for Controlled Substances revealed that on 3/20/26 thirteen (13) tablets of Klonopin (clonazepam) 2 MG for Resident #1 were destroyed per facility policy and procedure. On 4/13/26 at 1:30 PM during interview LPN #3 confirmed that he had been on duty on the 100 Hall on the dayshift (7:00 AM through 3:00 PM) on 3/19/26 and that during the narcotics accountability count of the scheduled medications in the locked box in the 100 Hall medication cart he noted that the foil seal on the back of the blister pack of Resident #1's clonazepam had been punctured. He stated that upon further investigation it appeared that tablet #16 and tablet #17 had been replaced with two (2) unidentified tablets. He said that he and LPN #2 had reported the discovery to the Director of Nursing and the Administrator on the morning of 3/19/26. On 4/13/26 at 2:00 PM an interview with the Staffing Coordinator revealed she had participated in the facility investigation into the misappropriation of two (2) clonazepam tablets that belonged to Resident #1. She confirmed that she had administered drug test to the nurses responsible for the safekeeping of the 100 Hall medication cart and narcotics locked box therein; she reported that the facility was not able to determine when or by whom Resident #1's clonazepam was tampered with. On 4/13/26 at 2:15 PM during interview the DON confirmed that on 3/19/26 nursing staff determined that two clonazepam 2 milligram tablets that belonged to Resident #1 had been misappropriated and replaced with two unidentified tablets. Record review of the Admission Record for Resident #1 revealed the facility admitted her on 2/09/26 and she had diagnoses of myasthenia gravis, abnormalities of gait and mobility and lack of coordination. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 2/15/26 for Resident #1 revealed that the facility assessed her Brief Interview for Mental Status score as 13, which indicated no cognitive impairment.	F0602		