| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**04/30/2026** |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MADISON CO NH** | **1421-A EAST PEACE STREET , CANTON, Mississippi, 39046** |

| (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 |
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| M0000 | Initial Comments<br><br>The State Agency (SA) conducted an Annual Re-licensure survey along with two (2) Complaint Investigations (CI MS #2985748 and CI MS #2988845), at the facility from 4/27/26 to 4/30/26. CI MS #2985748 was investigated related to staffing, housekeeping, and residents left wet and soiled and there were no deficiencies related to that CI. CI MS #2988845 was a Facility Reported Incident (FRI) regarding physical abuse and M500 was cited, however, based on the implementation of the facility's corrective actions on 04/22/2026, the deficient practice was determined to have been corrected as of 04/23/2026. During the re-licensure survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M1570. | M0000 | | |
| M0000 | Initial Comments<br><br>The State Agency (SA) conducted an Annual Re-licensure survey at the facility from 4/27/26 to 4/30/26. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care unit. There were no deficiencies cited.<br><br>The census at the time of the survey was 17 with a bed capacity of 20. | M0000 | | |
| M0500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; | M0500 | "Past Noncompliance - no plan of correction required" | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| M0500 | Continued from page 1<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; | M0500 | | |

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| M0500 | Continued from page 2<br><br>7. is free from mental and physical abuse;<br><br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br><br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so | M0500 | | |

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| M0500 | Continued from page 3<br>would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review and facility policy review, the facility failed to ensure the resident's right to be free from abuse for one (1) of (20) sampled residents. Resident #53.<br><br>Findings include:<br><br>Record review of facility policy; “Abuse Policy and Procedure” , revision date April 2021 revealed, “Residents have the right to be free from abuse… Policy interpretation and implementation: The resident abuse, neglect and exploitation prevention program consist of facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse… by anyone including but not necessarily limited to: a. facility staff...”<br><br>Record review of the facility investigation dated 4/21/26 revealed on 4/17/26 CNA # 1, Certified Nurse Aide (CNA), reported to Licensed Practical Nurse (LPN) # 4, that Resident #1 had a bruised left eye. Review revealed CNA # 1 reported the injury may have occurred while pushing Resident #53 to the dining table due to the resident’s short, stooped posture. Record review further revealed the CNA reported Resident #53 used a racial slur toward her and she verbally responded but denied striking the resident.<br><br>During an interview on 04/27/2026 at 11:30 AM, with Resident #53 she was unable to recall the incident in question. | M0500 | | |

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| M0500 | Continued from page 4<br><br>During an interview on 04/28/2026 at 2:00 PM, LPN #4 stated Resident #53 reported being hit in the eye by CNA #1. LPN#4 stated CNA # 2 reported she heard a commotion but did not witness the incident. She stated that when CNA #2 observed the resident's injury and asked what happened, Resident #53 reported she struck CNA #1 and was struck back in the eye, while making a motion consistent with a slap. She stated the resident provided a similar account to her. LPN # 4 revealed she reported the incident and removed CNA #1 from the unit with instructions not to return.<br><br>During an interview on 04/28/2026 at 2:45 PM, CNA #2 stated she heard a commotion and later observed bruising to Resident #53's left eye. She stated that when she asked what happened, Resident #53 reported she hit CNA #1 and was hit back in the eye, while making a motion consistent with a slap.<br><br>During an interview on 04/29/2026 at 11:00 AM, the Social Services Director stated she interviewed Resident #53 to assess psychosocial status following the incident. She reported the resident voiced no complaints and stated she felt safe. She stated the resident did not recall the incident, which she attributed to advanced dementia. She stated all residents assigned to the staff member involved were interviewed to assess any concerns related to abuse, neglect, or exploitation. She reported no additional allegations or concerns were identified. She stated she will continue to monitor Resident #53 for any changes in mood, behavior, or psychosocial well-being and will follow up as needed.<br><br>During an interview on 04/29/2026 11:15 AM, the Director of Nurses (DON) revealed that following the investigation, it was determined that CNA # 1 struck Resident # 53 in the eye. She stated the staff member was removed from duty during the investigation and was subsequently terminated once the allegation was substantiated. The Administrator stated Resident # 53 was assessed by nursing the following day. On 04/21/2026, an emergency Quality Assurance and Performance Improvement meeting was conducted upon determination that abuse occurred. She stated Social Services interviewed the resident to assess psychosocial status. The resident voiced no additional complaints and did not recall the incident, which was attributed to advanced dementia. She further revealed that all residents assigned to CNA #1 were interviewed by Social Services, and no additional concerns were identified. The Resident Representative was notified by the Administrator and Director of Nursing regarding the | M0500 | | |

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| M0500 | Continued from page 5<br>investigation findings and cause of the injury. The Administrator stated a report was filed with the county police department. Written reports were submitted to the State Agency and the Attorney General's Office. She reported all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using Centers for Medicaid and Medicaid Services (CMS) Hand in Hand Module 5, as well as crisis intervention and de-escalation tools. She stated a memo was posted at the time clock directing staff to complete training at the start of their shift, and designated staff monitored compliance. All staff completed the required training by 04/22/2026.<br><br>During an interview on 04/29/2026 at 11:38 AM, the Licensed Nursing Home Administrator (LNHA) stated that following the facility investigation, it was determined that CNA # 1 struck Resident #53 in the eye. He stated the staff member was immediately removed from duty during the investigation and was terminated upon confirmation of the allegation. He stated it was his decision to make the final determination to terminate CNA #1 even though it was not witnessed. He stated the resident was assessed by nursing the following day. He reported that on 04/21/2026, once the allegation was substantiated, the facility conducted an emergency Quality Assurance and Performance Improvement meeting. He stated Social Services interviewed the resident to assess psychosocial status. He reported the resident voiced no additional concerns and did not recall the incident, which he attributed to advanced dementia. He further stated all residents assigned to CNA #1 were interviewed by Social Services, and no additional concerns were identified. He confirmed the Resident Representative was notified by the Administrator and Director of Nursing regarding the findings of the investigation. He stated a report was filed with the county police department and written reports were submitted to the State Agency and the Attorney General's Office. He stated all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using CMS Hand in Hand Module 5, as well as crisis intervention and de-escalation techniques. He reported a memo was posted at the time clock directing staff to complete the training at the beginning of their shift, and staff compliance was monitored. He confirmed all staff completed the required training by 04/22/2026.<br><br>Record review of the "Face Sheet" revealed Resident # 53 was admitted 11/20/25 to the Memory Care Unit | M0500 | | |

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| M0500 | Continued from page 6<br>with diagnoses including Alzheimer's disease, cognitive communication deficit, and unspecified dementia with behavioral disturbance.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment.<br><br>Record review of the Social Services progress note dated 4/21/26 at 12:31 PM, revealed Social Services and the Assistant Administrator followed up with Resident #53 upon her return from a supervised joy ride and after lunch to assess emotional and psychosocial status related to the alleged abuse incident. Documentation revealed when asked how she was doing and if everything was going okay, Resident #53 stated, "It's good." When asked if she felt safe, the resident responded, "Yes." Record review revealed the resident was documented to be in a good mood, voiced no concerns, and expressed no issues at the time of the follow up.<br><br>Record review of the facility's abuse investigation concluded Resident #53 did not sustain the injury by accidentally striking the dining table and the facility determined that CNA # 1 struck Resident #53 in the eye. CNA # 1 was suspended pending investigation and subsequently terminated. The facility reported the allegation to the State Agency, the Attorney General's Office, and local law enforcement. The facility conducted an emergency Quality Assurance Performance Improvement (QAPI) meeting, notified the Resident Representative, interviewed additional residents assigned to CNA #1 and educated staff regarding abuse prevention, resident rights, recognizing burnout, and preventing abuse.<br><br>Record review of the progress note dated 4/17/26 at 1:39 AM revealed acute follow up assessment related to left orbital ecchymosis from an injury identified on the prior shift. Documentation revealed a dark red circular bruise to the left eye region, dark purple bruising along the lateral bridge of the nose extending to the superior left cheek, tenderness on palpation, minimal edema, and complaint of pain with the resident stating, "It's sore." The residents' pupils were equal, round, and reactive to light and accommodation. Documentation noted due to advanced Alzheimer's disease, the resident was unable to reliably express symptoms such as blurred vision, double vision, dizziness, or headache, however nursing documented no apparent visual disturbance at that time. Interventions included staff assistance with transfers and toileting for safety, head of bed elevated to 45 degrees to reduce | M0500 | | |

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| M0500 | Continued from page 7<br>bruising, application of cold compresses to the eye area twice for ten minutes to reduce edema, and continued monitoring. Documentation revealed no acute distress, respirations even and unlabored, skin warm and dry, and resident resting quietly in bed. Vital signs were documented as temperature 97.5, pulse 79, respirations 16, and blood pressure 121/67. Further documentation revealed continued treatment and monitoring were implemented. | M0500 | | |
| M1570 | 48.58.1 Infection Control<br><br>The following infection control standards shall be met:<br><br>1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.<br><br>2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases.<br><br>3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, facility policy review and record review, the facility failed to ensure staff followed infection prevention and control practices to prevent the spread of infection during resident care for two (2) of five (5) care observations. Resident #2 and Resident #82.<br><br>Findings Include:<br><br>Record review of the facility policy “Policy for Handwashing” undated, revealed, “Objective: To prevent and to control the spread of infectious | M1570 | | |

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| M1570 | Continued from page 8<br>disease.1. Appropriate 15 second hand washing with antimicrobial soap and water must be performed under the following conditions: a. when hands are visibly dirty or soiled with blood or other body fluids; b. after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; c. after handling items potentially contaminated with blood, body fluids, or secretions; d. before eating; e. after using a restroom...3. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. before direct contact with residents…f. after removing gloves.<br><br>Record review of the facility policy “Enhanced Barrier Precautions” (EBP) dated 8/2022 revealed, “… EBP are used as an infectious prevention and control interventions to reduce the spread of multi-drug-resistant organisms (MDROs) to residents... 2.a.Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room)…5. EBP are indicated (when contact precautions do not otherwise apply) for residents with wounds and or indwelling devise regardless of MDRO colonization...9. Staff are trained prior to caring for residents on EBP’s...”<br><br>Resident # 2:<br><br>In an interview with resident #2 at 2:08 PM on 4/28/26, he stated that he had been dealing with a urinary tract infection (UTI) in the past month requiring treatment with antibiotics.<br><br>On 04/28/2026 at 2:17 PM, Registered Nurse (RN) #1 was observed performing catheter care. During the procedure, the nurse dropped a washcloth onto the bed linen, retrieved it, and used the same contaminated washcloth to cleanse the catheter site. The nurse then touched the bathroom door handle while wearing contaminated gloves after completing care.<br><br>During an interview on 04/28/2026 at 2:21 PM, RN #1 stated she should have discarded the washcloth once contaminated and performed hand hygiene after removing gloves before touching environmental surfaces. She confirmed her actions created a risk for cross contamination.<br><br>During an interview on 04/29/2026 at 2:31 PM, the Director of Nursing (DON) stated the nurse should have discarded the contaminated washcloth and performed hand hygiene after glove removal. She confirmed staff are expected to follow infection | M1570 | | |

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| M1570 | Continued from page 9<br>prevention policies.<br><br>During an interview on 04/30/2026 at 11:01 AM, the Infection Preventionist (IP) stated proper catheter care requires discarding contaminated supplies and performing hand hygiene after glove removal to prevent cross contamination.<br><br>Record review of the “Face Sheet” revealed Resident # 2 was admitted to the facility on 6/14/22 with a diagnoses that included central cord syndrome.<br><br>Record review of the Minimum Data Set (MDS) section C with an Assessment Review Date (ARD) of 4/14/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.<br><br>Record review of the “Physician Order Report” dated 3/28/26-4/28/26 revealed an order dated 2/10/25 “Record catheter output q (every) shift.”<br><br>Resident # 82:<br><br>On 04/28/2026 at 3:20 PM, Licensed Practical Nurse (LPN) #1 was observed administering medications via Percutaneous Endoscopic Gastrostomy (peg) tube to Resident #82. The nurse entered the room and donned (put on) gloves without performing hand hygiene. While wearing the same gloves, the nurse touched multiple surfaces including the faucet, medication cart, computer mouse, privacy curtain, and bed controls prior to initiating care. The nurse did not don a gown. The nurse administered medications via peg tube without changing gloves or performing hand hygiene during the process. After completing the procedure, the nurse removed gloves and exited the room without performing hand hygiene.<br><br>During an interview on 04/28/2026 at 3:40 PM, LPN#1 stated she had not received training on Enhanced Barrier Precautions (EBP) and acknowledged she failed to perform hand hygiene, wear a gown, and change gloves. She confirmed this created a risk for cross contamination.<br><br>During an interview on 04/29/2026 at 3:12 PM, the IP stated LPN #1 had not completed required infection control training. She stated the nurse should have performed hand hygiene upon entry, worn a gown, and changed gloves after contact with environmental surfaces. She confirmed the observed practice exposed the resident to infection risk.<br><br>During an interview on 04/29/2026 at 3:38 PM, the | M1570 | | |

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| M1570 | Continued from page 10<br>DON stated LPN#1 should have completed required training, performed hand hygiene, and worn a gown during peg tube medication administration. She confirmed failure to follow these practices increased the risk of infection.<br><br>Record review of Resident #82 "Face sheet" revealed an admission date of 11/11/20 with diagnoses that included Hemiplegia, unspecified affecting right dominant side and cerebral palsy, unspecified.<br><br>Record use of the “Physician Order Report” revealed orders dated 6/6/23 for Calcium 500 plus D (calcium carbonate-vitamin d), phenobarbital 64.8 mg (milligrams) and an additional order dated 7/24/25 for phenytoin tablet chewable via peg tube.<br><br>Record review of the MDS with an ARD of 2/23/26 revealed a BIMS score of (3) indicating the resident had severe cognitive impairment. | M1570 | | |