Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

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
M0000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #3016973 and CI MS #2995773 at the facility from 5/26/26 to 5/27/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #3016973 was investigated related to nursing services and educational services and no deficiencies were cited. CI MS #2995773 was investigated for infection control, quality of care and nursing services and M615 and M1570 were cited.	M0000		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure physician ordered Negative Pressure Wound Therapy (NPWT) was monitored and maintained in working order for one (1) of three (3) residents reviewed for wound care. Resident #2. Findings Include: Record review of the facility policy “Negative Pressure Wound Therapy (NPWT)" dated 7/2025 revealed, “...9. Monitoring throughout the use of NPWT shall include, but is not limited to, the following: a. Pain associated with the therapy. b. Device is functioning. c. Settings as prescribed. d. Troubleshooting of any alarms, in accordance with pump/product specifications. e. Response of the therapy, including wound characteristics and progress towards healing...” A record review of the “Order Summary Report” with	M0615		

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

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M0615	Continued from page 1 active orders as of 5/27/26 revealed an order dated 04/24/26 for treatment of a Stage IV sacral pressure injury with Negative Pressure Wound Therapy at 125 mmHg (millimeters of mercury) continuous pressure with dressing changes every Monday, Wednesday, and Friday and as needed. During an observation on 05/26/26 at 12:30 PM, Resident #2's wound vacuum machine was observed connected to the resident but not functioning. The screen was not illuminated, no sounds were emitted from the unit, and no drainage was observed moving through the tubing. During a follow up observation on 05/26/26 at 2:30 PM, while incontinent care was being provided, the wound vacuum remained connected to the resident and continued to be nonfunctional. Following completion of incontinent care, the wound vacuum dressing was observed to have lost its seal and become detached. During an interview on 05/26/26 at 2:45 PM, Certified Nurse Assistant (CNA) #1 stated she was unaware the wound vacuum was not functioning prior to providing care and indicated she would notify the wound care nurse. Resident #2 and her granddaughter stated the resident frequently remains incontinent for extended periods despite using the call light. They stated the resident has a chronic Stage IV sacral wound and urine often causes the wound vacuum dressing to lose its seal. They further stated staff do not routinely monitor the wound vacuum's function. They reported that on the day of observation, Resident #2 returned from physical therapy wet with urine, called for assistance multiple times, and no staff responded before incontinent care was eventually provided. They stated the wound vacuum was not functioning during therapy and remained nonfunctional afterward. During an interview on 05/27/26 at 9:05 AM, Licensed Practical Nurse (LPN) #1, the wound care nurse, stated staff had been instructed to notify her if a wound vacuum was not working and to apply a wet to dry dressing if the device became nonfunctional until she could assess the resident. She stated no staff member notified her at approximately 12:30 PM on 05/26/26 that the wound vacuum was not functioning. She further stated she first became aware of the issue at approximately 2:45 PM when notified by CNA #1 after incontinent care had been completed. At that time, she contacted the Nurse Practitioner (NP) who instructed her to apply a wet to dry dressing rather than	M0615		

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M0615	Continued from page 2 reapply the wound vacuum. During an interview on 05/27/26 at 9:15 AM, the Director of Nursing (DON) stated the facility did not have routine checks of wound vacuum functionality in place, such as every two hours. The DON stated implementing such monitoring may be necessary to ensure devices are functioning properly. The DON further stated a malfunctioning wound vacuum and prolonged exposure to urine could contribute to wound deterioration and infection. The DON stated nursing assistants are responsible for checking incontinent residents at least every two hours and providing care as needed to prevent skin breakdown and wound deterioration. During an interview on 05/27/26 at 2:10 PM, the NP stated a wound vacuum remaining inoperable for periods of time could delay wound healing. The NP further stated prolonged exposure to urine could contribute to breakdown of the peri wound tissue and reduce the wound's ability to heal. A record review of the “Admission Record” for Resident #2 revealed she was admitted on 04/10/26 with diagnoses that included nondisplaced fracture of the medial condyle of the right femur. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 04/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact.	M0615		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 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. 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	M1570		

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M1570	Continued from page 3 communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interviews, and facility policy review, the facility failed to implement and maintain an effective infection prevention and control program for one (1) of three (3) residents reviewed for infection control practices. (Resident #2) Findings Include: Record review of the facility policy “Enhanced Barrier Precautions" dated 10-23 revealed, “Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms...” Record review of the facility policy "Hand Hygiene Policy" dated 5-25 revealed, “…6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves…” During an observation on 05/26/26 at 2:35 PM, Resident #2 was observed receiving incontinent care. Certified Nurse Assistant (CNA) #1 removed a brief that was visibly heavily soiled and saturated with urine to the extent urine was observed leaking from the sides of the brief. During the provision of care, CNA #1 removed her gloves and applied a new pair prior to performing perineal care. Following perineal care, CNA #1 again removed her gloves and applied a new pair before providing bowel incontinence care. During each glove change, CNA #1 failed to perform hand hygiene prior to applying clean gloves. CNA #1 was also observed to provide incontinent care without wearing a gown despite Resident #2 being on Enhanced Barrier Precautions (EBP). During an interview on 05/26/26 at 2:45 PM, CNA #1 confirmed she failed to perform hand hygiene between glove changes. CNA #1 stated she should have performed hand hygiene between glove	M1570		

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M1570	Continued from page 4 changes to prevent the spread of infection. CNA #1 further confirmed she failed to wear a gown during care and stated she should have worn a gown to comply with EBP and prevent infection transmission. CNA #1 stated residents requiring EBP are identified by a green indicator outside the resident's room. During an interview on 05/27/26 at 9:15 AM, the Director of Nursing (DON) stated staff are expected to follow EBP when caring for residents with chronic wounds or indwelling medical devices and are expected to perform hand hygiene between each glove change to prevent the spread of infection. During an observation on 05/27/26 at 10:37 AM, Licensed Practical Nurse (LPN) #1 was observed providing wound care to Resident #2's Stage IV sacral pressure injury. During the procedure, LPN #1 used gauze to cleanse stool from the lower portion of the wound area. After discarding the soiled gauze, LPN #1, while continuing to wear the same gloves contaminated with fecal material, obtained additional gauze and proceeded to cleanse the wound bed. LPN #1 then obtained another gauze and cleansed the skin surrounding the wound without changing gloves or performing hand hygiene. During an interview on 05/27/26 at 11:18 AM, LPN #1 confirmed she cleansed the wound bed after removing stool from the wound area while wearing the same gloves. LPN #1 stated this practice could contaminate the wound with bacteria from stool and potentially result in wound infection, sepsis, increased drainage, increased slough, increased exudate, delayed healing, or cessation of wound healing. LPN #1 further stated Resident #2 had recently completed a course of antibiotics for a positive wound culture within the previous 14 days. During an interview on 05/27/26 at 11:27 AM, the DON stated the nurse should have removed contaminated gloves and performed hand hygiene before proceeding with wound care. The DON stated failure to do so could contaminate the wound and increase the risk of infection. The DON further stated her expectation was that staff follow infection prevention practices during all resident care. During an interview on 05/27/26 at 11:30 AM, the Infection Preventionist (IP) stated CNA #1 should have performed hand hygiene between glove changes and worn a gown as required by EBP. The IP further stated LPN #1 should have removed contaminated gloves and performed hand hygiene after handling stool contaminated materials before cleansing the wound bed. The IP stated failure to	M1570		

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M1570	Continued from page 5 follow these infection prevention practices increased the risk of contaminating the wound and exposing the resident to infection. A record review of the “Admission Record” for Resident #2 revealed she was admitted on 04/10/26 with diagnoses that included nondisplaced fracture of the medial condyle of the right femur. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 04/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact. A record review of the “Order Summary Report” with active orders as of 5/27/26 revealed an order dated 04/24/26 for treatment of a Stage IV sacral pressure injury with Negative Pressure Wound Therapy (NPWT) at 125 mmHg continuous pressure with dressing changes every Monday, Wednesday, and Friday and as needed. The record also revealed an order for Enhanced Barrier Precautions dated 05/26/26.	M1570		