STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification along with complaint investigations (CI) MS00018572 and CI MS00018185 from 4/4/2022 through 4/7/2022. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA substantiated CI MS00018572 for Quality of Care for resident not being groomed adequately and Residents Rights for resident not treated with dignity and cited M500 and M610. The SA did not substantiate CI MS00018185 for employee to resident abuse. The SA also cited M640, M815, M945 and M1230. The facility had a census of 54 and held a license for 60 beds at the time of survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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; 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;	M 500		5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 1 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; 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; 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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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M 500	Continued From page 2	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

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;

7. is free from mental and physical abuse;
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;
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;

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;

11. is not required to perform services for the facility that are not included for therapeutic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 3 purposes in his plan of care; 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); 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); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 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 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.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observation, staff interviews, resident interviews, record review, and facility policy review, the facility failed to ensure that each resident was treated with dignity as evidenced by failure to provide verbal communication to residents during care, knock on resident's door before entering, cover a resident and close door during care, and failure to provide a privacy bag for a catheter for 4 of 24 residents observed. Resident #19, #27, #42, #43. Findings Include Resident #27 Review of the facility policy titled, "Promoting/Maintaining Resident Dignity" with a revision date of 1-19, revealed, " It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. " Under "Compliance Guidelines." #1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights...#5. When interacting with a resident, pay attention to the resident as an individual... #7. Explain care or procedures to the resident before initiating the activity. #8. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused, and resident centered...#12. Maintain resident privacy."	M 500	On 4/7/2022, certified nursing assistants were inserviced on promoting/maintaining resident dignity related to resident #27 and #43 including knocking before entering room introducing self, explaining care, and interacting with resident during care. On 4/7/22, Certified nursing assistants were inserviced on keeping resident covered and door closed during care including resident #19. On 4/7/22, resident #42 foley catheter bag was placed in a privacy bag. All residents have the potential to be affected by this deficient practice. On 4/7/2022 the Director of Nursing began inservicing all certified nursing assistants and nurses on promoting and maintaining residents' dignity. Inservice complete on 4/28/2022. On 4/6/2022, all residents with Foley catheters were provided a fig leaf bag or privacy bag by registered nurse Supervisor and Director of Nursing began inservicing all nurses and certified nursing assistants on providing all residents with a foley catheter a privacy bag or fig leaf bag to maintain dignity. Inservice complete on 4/28/2022. The Staff Development Coordinator or Director of Nursing will conduct three (3) observations for providing dignity, privacy with foley catheter bag beginning 5/5/22 per week for the next three (3) months to ensure staff are promoting and maintaining resident dignity in accordance with our facility's practice guidelines and regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 5 An observation on 04/04/22 at 11:59 AM, revealed Certified Nurse Assistant (CNA) #7 yelled from Resident #27's room to CNA #6 who was in the hall and asked her to come help pull the resident up in the bed. State Agency (SA) observed CNA #6 enter Resident #27's room without knocking and assisted CNA #7 to pull the resident up in the bed. Observed that neither CNA spoke to the resident while performing the task and before leaving the resident's room. An interview on 4/5/22 at 3:30 PM, with CNA #5 revealed that when staff enters a resident's room the staff member should knock on the door, speak to them, and let them know why they are entering their room. She revealed that not speaking to a resident while performing care would be rude and a dignity issue. She revealed that it is all about how you approach people when providing care. An interview on 4/5/22 at 4:30 PM, with CNA #8 revealed that the staff should always knock and tell the resident their name and what you are needing to do when entering their room. An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed she did not remember not speaking to Resident #27 while helping pull her up in the bed. She revealed that	M 500	Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 6	M 500		

she feels like sometimes the staff gets in a hurry and busy trying to complete the task and forget we need to socialize with them more.

An interview on 4/7/22 at 10:00 AM, with the Director of Nursing (DON) revealed that staff should knock on the resident's door and introduce themselves if the resident does not know them, explain the care that needs to be performed and just socialize with them. She revealed that she is not sure if it would be a dignity issue or just non-sociable when a staff member does not speak to a resident while performing care

An interview on 4/7/22 at 12:15 AM, with Resident #27 revealed that most of the time the staff does not speak to her when they come in to do something. She revealed that the staff will talk to each other in front of her, sometimes they have their blue-tooth headphones on and take personal phone calls on their cell phones. She revealed that she does not care if they want to ignore her, but it would be nice to be included.

Record review of Resident #27's Admission Record revealed an admission date of 10/09/15 with medical diagnoses that include Type 2 Diabetes Mellitus and Major Depressive Disorder.

Record review of the residents Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/22 revealed a Brief Interview of Mental Status (BIMS) of 15, which indicates the resident is cognitively intact.

Resident #43

An observation on 04/04/22 at 10:40 AM, revealed Resident #43 lying in bed, awake, alert

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 7	M 500		

and with speech that is hard to understand due to a Cerebrovascular Disease with an onset date of 10/15/13. An observation of CNA #7 enter the resident's room with a fresh glass of water and sit it on the resident's over-bed table. Observed CNA #7 point to the two glasses of water that were already on his over-bed table without speaking. Observed the resident speak to CNA #7, pull one of the glasses toward him and pushed the other glass toward the CNA #7. CNA #7 took the glass of water that the resident pushed toward her and left the room without speaking to the resident.

An observation on 4/4/22 at 12:25 PM, revealed Resident #43 lying in bed, awake and alert. Observed CNA #6 enter Resident #43's room with his lunch tray, set it up on his over-bed table and leave the room without speaking to the resident.

An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed Resident #43 is hard to understand, but she did not remember, not speaking to him while setting his lunch tray up. She revealed that she feels like sometimes the staff get in a hurry and busy trying to complete the task and forget we need to socialize with them more.

An interview on 4/7/22 at 11:58 AM, with Resident #43 revealed the staff usually does not talk to him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 8 when they come in his room. Record review of Resident #43's Admission Record revealed an initial admission date of 10/15/13 and medical diagnoses that include Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting right dominant side. Record review of Resident #43's MDS with an ARD of 2/26/22 revealed a BIMS of 15, which indicates the resident is cognitively intact. Resident #19 On 04/04/22 at 10:18 AM, an observation of Resident #19 from the hallway, revealed the door was open, and Resident #19 was lying in bed with only a brief on. No top sheet or blanket was covering him. On 04/05/22 at 08:51 AM, an observation of Resident #19 from the hallway, revealed him lying in bed exposed with only a brief on. Licensed Practical Nurse (LPN) #1 was in the room working on the resident's gastrostomy tube. The nurse exited the room leaving the door open with the resident remaining exposed with only a brief on. A Certified Nursing Assistant (CNA) entered the room closing the door behind her. An interview on 04/06/22 at 03:02 PM, with Licensed Practical Nurse (LPN) #1 revealed that Resident #19 should be covered when the door is	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 9	M 500		

open. LPN #1 stated that it could embarrassing to him, and it is a dignity issue.

Record review of Resident #19's Admission Record revealed the resident was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Dysphagia, Convulsions, and a Personal History of Traumatic Brain Injury.

Record review of MDS with an ARD of 01/25/2022 revealed Resident #19 with a BIMS score of 03, which indicated the resident has severe cognitive impairment.

Resident #42

Review of facility policy titled, "Maintaining Privacy and Dignity For Residents with Foley Catheter Drainage Bags", with a revision date of 2/16 revealed, " It is the policy of this facility to provide privacy and dignity to all residents that have a urinary drainage bag in use. The procedure revealed the drainage bag will be maintained in a storage pouch to hide the contents and prevent embarrassment to the resident".

On 04/04/22 at 10:57 AM, 12:05 PM, and 03:05 PM, observations revealed Resident #42's urinary catheter bag was visible to the hallway. The catheter bag was on the right-hand side of the bed facing the entrance room door without a privacy bag. Urine was noted in urinary catheter bag.

On 04/05/22 at 8:50 AM, and again at 3:50 PM, observations revealed Resident #42's urinary catheter bag on the right side of the bed facing the entrance room door without a privacy bag and visible to the hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 500	Continued From page 10 During an observation on 04/06/22 at 09:33 AM , Resident #42's urinary catheter bag was on the right side of the bed without a privacy bag and facing the entrance room door. The catheter was visible from the hallway. During an observation and interview, on 04/06/22 at 1:00 PM, with the Director of Nurses (DON), she confirmed the resident had a privacy bag on the back of his wheelchair, but he should have a privacy bag for his bed, and his catheter bag should not be visible to the hallway. A record review of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022 with diagnoses of Neuromuscular Dysfunction of the Bladder and Fracture of Left Femur. Record review of the MDS with an ARD of 02/22/2022, revealed Resident #42 had a BIMS score of 15, which indicated the resident was cognitively intact.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting.	M 610		5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 610	Continued From page 11 This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, facility policy review and record review, the facility failed to provide personal hygiene as evidenced by long and jagged nails and flecks of white material in resident's hair for 2 of 24 residents observed. Residents #42 and Resident #19. Findings include: A record review of the facility policy "Fingernails/Toenails, Care of", undated, revealed, "Policy The purposes of this policy is to clean the nail bed, to keep nails trimmed, and to prevent infections ...Procedure ...6. Nail care includes daily cleaning and regular trimming ... 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin... " A record review of the facility policy titled "Shampooing Hair Policy", undated, revealed, Policy ... The purpose of this policy is to clean and maintain the resident's with healthy hair and scalp. Procedure 1. Use a comb to remove any tangles before washing the hair." Two observations on 04/04/22 at 10:44 AM and at 12:11 PM, of Resident #19 lying in his bed. His hair was matted with white fuzz in it. Nails are long and jagged approximately one -half (1/2) inch past the tip of the fingers on each hand. During an observation on 04/05/22 at 09:14 AM, Resident #19 was lying in bed, hair matted with white fuzz in it. Nails continue to be long and	M 610	Resident #19 and resident #42 fingernails were cut on 4/6/22. Resident #19 hair was cleaned and combed on 4/6/22. Nailcare be performed daily as needed and hair will be combed daily. All residents have the potential to be affected by this deficient practice. The Director of Nursing inserviced all certified nursing assistants and nurses beginning on 4/6/22 and completed on 4/28/22 on Activities of Daily Living". The Director of Nursing or registered nurse supervisor, will conduct three (3) observations of resident activities of daily living per week x six (6) weeks beginning 5/2/22 to ensure activities of daily living care is provided to residents. Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months beginning 5/12/22 to assure substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 610	Continued From page 12	M 610		

jagged approximately 1/2 inch past the tip of the fingers on each hand.

An observation on 04/06/22 at 11:12 AM, revealed Resident #19 lying in bed. His hair was matted with white fuzz. Fingernails were long and jagged approximately 1/2 inch long past the tips of fingers on both hands.

An interview and observation on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the resident's nails are long and jagged and need to be trimmed and smoothed out. CNA
#1 confirmed the jagged edges of the nails could cut us or the resident could cut himself. CNA #1 also confirmed that the resident has white fuzz in his hair. She stated she is not sure where it comes from but it is always like that. She stated, "the resident's hair could be picked out."

An interview and observation on 04/06/22 at 01:05 PM, the Director of Nurses (DON) removed a piece of white material from the resident's hair and stated that it looks like fuzz. The DON confirmed this should not be in his hair. She also confirmed the resident's nails are long and need to be trimmed. She stated that he could scratch and hurt himself with the jagged nails and she would make sure they get trimmed.

A record review of the Admission Record for Resident #19 revealed he was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Anxiety, Convulsions, and a Personal History of Traumatic Brain Injury.

Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/25/2022 revealed Resident #19 with a Brief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 610	Continued From page 13 Interview for Mental Status (BIMS) score of 03, which indicated resident has a severe cognitive impairment, requires extensive assistance of one person with personal hygiene. and total assistance of one person with bathing. Resident #42 An observation on 04/04/22 at 10:20 AM and at 3:10 PM, revealed Resident #42's fingernails long and approximately 1/2 inches past the tips of fingers on both hands. An observation on 04/05/22 at 08:50 AM, revealed Resident #42's fingernails untrimmed. An observation and interview on 04/05/22 at 03:50 PM, revealed Resident #42's fingernails untrimmed. The Resident stated that he doesn't know the last time his fingernails were trimmed. Observations on 04/06/22 at 09:15 AM and again at 12:50 PM, revealed the resident's fingernails continued to be untrimmed and approximately 1/2 inch past the tips of fingers on both hands. An observation and interview on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the nails are long and needed to be trimmed and smoothed out. Resident #42 stated that he would like his fingernails cut. An observation and interview, on 04/06/22 at 01:00 PM, with the Director of Nurses (DON) confirmed his nails were long and need to be trimmed. The DON stated, "I will make sure this gets done. " A record review of Resident #42's Admission Record revealed the resident was admitted to the	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 610	Continued From page 14 facility on 02/16/2022, with diagnoses of Neuromuscular Dysfunction of the Bladder, Chronic Gout, and Fracture of Left Femur. A record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/22/2022, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact and requires extensive assistance of one person with personal hygiene.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, resident interviews, staff interviews, record review, and facility policy review, the facility failed to ensure a resident who was at risk for wandering was appropriately monitored and supervised to prevent wandering into other residents' rooms for one (1) of four (4) survey days. Resident #46. Findings include: A review of facility policy titled, "Resident at Risk for Wandering Behavior," dated February 2017, revealed, "This facility ensures that residents who exhibit wandering behavior receive adequate	M 640	Resident #46 was placed on one on one on 4/4/22 and sent to the behavioral health for evaluation on 4/5/22. Resident returned to facility on 4/18/22 and placed one on one supervision until a transfer could be made. Resident was transferred to a memory care unit on 4/29/22 for a more secure environment. All residents have the potential to be affected by this deficient practice. Director of Nursing completed in-service of all staff on 4/28/22 on the facility policy for wandering behaviors. Those at high risk for wandering will be placed on every	5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 15 supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy explanation and compliance guidelines: 'Wandering' is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or not-goal directed or aimless..." Observation and interview on 4/4/22 at 3:05 PM, the State Agency (SA) tried to locate Resident #46. An interview with Certified Nurse Assistant (CNA) #6 revealed she had seen the resident a few minutes earlier in the hallway near his room. CNA #6 asked other staff about Resident #46's location and these staff members looked for the resident. An observation on 4/4/22 at 3:12 PM, revealed CNA #6 located Resident #46 in the bathroom of Resident #35's room, two doors down from his room. The resident living in that room was noted to be in bed and appeared to be asleep. An interview with CNA #6 on 4/4/22 at 3:15 PM, revealed Resident #46 rolled his wheelchair up and down the halls and in and out of residents' rooms to visit, but "he is not a wanderer or exit seeking." An interview on 4/5/22 at 4:15 PM, with Resident #9, revealed the man living in the room next to hers came into her room last night, even though her door was closed. She stated she told him to get out and he did, but he came back. She stated several minutes ago, the same resident was trying to go into her room again and she did not let him in. She stated she does not want him in her room and wants someone to help her keep	M 640	1 hour monitoring. The Director of Nursing or registered nurse supervisor, will complete four (4) weekly chart audits for six (6) consecutive weeks beginning 5/2/22 to ensure that appropriate interventions have been put in place for residents who have been determined to be at high risk for wandering to ensure resident safety and that care plans have been updated to reflect these interventions. Observation reports will be reviewed by the Quality Assurance Committee monthly beginning 5/12/22 x two (2) months to assure substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 16	M 640		

him out.

An interview with CNA #8 on 4/5/22 at 4:20 PM, revealed she did not witness the interaction between Resident #46 and Resident #9. She stated that concerning Resident #46, "a lot of residents have problems with him going in and out of their rooms." Stated she had not reported this since everyone was aware of Resident #46's wandering.

An interview with Licensed Practical Nurse (LPN) #1 on 4/5/22 at 4:25 PM, revealed Resident #46 wandered around the facility but was not exit seeking. She stated he recently started approaching other residents' rooms and had wandered into other residents' rooms. She stated even though he went into other residents' rooms, "he doesn't mean anything by it."

An interview with LPN #6 on 4/5/22 at 4:30 PM, revealed in the previous facility building Resident #46 wandered and took items from people, but he had been more calm in the new building. She stated the resident is not exit seeking, but he does roll around the hallways and has gone into other residents' rooms. She stated she had not reported this since it was known to all the staff.

An interview with CNA #4 on 4/5/22 at 4:55 PM, revealed Resident #46 had wandered into other residents' rooms and had to be redirected. She stated she had not reported to the charge nurses because everybody knew he wandered and they were "seeing him wander, too."

An interview with Registered Nurse (RN) #2 on 4/5/22 at 5:08 PM, revealed Resident #46 had recently started wandering the halls and for the past few days, he had been wandering into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 17	M 640		

residents' rooms. She stated when the resident was in another resident's room, the staff asked them about Resident #46 being in their rooms and they said they were "okay with it." She stated his condition had deteriorated over the past several weeks and currently requiring more assistance and redirection. She stated Resident #9 had told her Resident #46 came into her room.

An interview with CNA #5 on 4/5/22 at 5:11 PM, revealed, Resident #46 "goes up and down the halls and in and out of rooms." She stated he would go into a room, look around, and come back out. She stated he would occasionally try to take someone's food, but nothing else.

An interview with the Director of Nurses on 4/5/22 at 5:00 PM, revealed Resident #46 had wandered up and down the halls and doorways recently, but she did not realize he went into other residents' rooms. She stated she should have known this was occurring to have helped decrease this behavior.

An interview with Resident #42 on 4/5/22 at 5:18 PM, revealed Resident #46 had come into his room a few days ago. He stated he just rolled in and then rolled back out. He stated that was the only time that had happened.

An interview with Resident #43 on 4/5/22 at 5:20 PM, revealed that several times a man resident in a wheelchair had come into his room and has looked around then turned around and went back out.

An interview with Resident #27 on 4/5/22 at 5:25 PM, revealed a resident in a wheelchair had come into her room and told her that her room was his room, but she told him it was her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 18	M 640		

and he left. She stated she thought it had happened other times, but she was not sure when.

An interview with RN #2 on 4/7/22 at 9:35 AM, revealed Resident #46 had been wandering up and down the hall and went into other residents' rooms to visit. She stated she only knew of one incident when he went into the bathroom of another resident on the day that SA entered the building. She stated she did not report his wandering since it was not noted to her that this was wanderings.

An interview with CNA #5 on 4/7/22 at 9:45 AM, revealed Resident #46 goes in rooms and comes out. She stated no one had reported to her about him staying in a room and she had not reported to anyone since he just "goes in and looks around then comes out."

An interview with LPN #1 on 4/7/22 at 10:15 AM, revealed the resident would roll up and down the hallway and would go to other resident's doorway and would look in and she would hear the other resident fussing at him to leave. She stated the resident left and the staff redirected him. She stated she had never seen him actually in another resident's room, but he would be in the doorway. She stated it had never been reported to her that he was in another's resident's room and she had not reported since he was not all the way in another person's room. The SA asked her about her earlier statement about resident going into other resident's rooms and she said it was in the doorway and not into the room.

An interview with the Minimum Data Set (MDS) Coordinator on 4/7/22 at 10:45 AM, revealed Resident #46 had a quarterly care plan meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 19	M 640		

on 3/31/22 and his wandering was discussed in the meeting. She stated the resident's behavior of wandering goes "way back" and apparently it had improved over time and had recently become an issue again. She stated this was discussed and they discussed interventions for his wandering. She stated they discussed keeping an eye out on him to keep him out of other residents' rooms, redirecting him, and offering activities for him.

An interview with the Social Worker on 4/7/22 at 11:00 AM, revealed Resident #46's care plan meeting was on 3/31/22. She stated that recently after his last hospitalization, his wandering seemed to increase. She stated he had always enjoyed rolling in the hallways, but recently he was going into other residents' rooms. She stated this was discussed in the last care plan meeting and interventions for staff to watch him and to redirect him were also discussed.

An interview with the Activity Director on 4/7/22 at 11:45 AM, revealed she attended Resident #46's most recent care plan meeting. During the meeting, it was discussed about his increased wandering in the hallways and into some of the resident's rooms. She stated interventions discussed were to watch him closely, redirect him, talk to him, and give him activities.

An interview with the DON on 4/7/22 at 1:00 PM, revealed she was unaware of Resident #46's recent increase in wandering. She stated she had not read the recent notes or care plan meeting notes on the resident's wandering and she was unaware of his history of wandering. She stated she was aware he was rolling up and down the hallway, but was not aware of him going into other residents' rooms. The DON confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 640	Continued From page 20	M 640		

the facility failed to ensure the resident was monitored closely to prevent his wandering into other residents' rooms. She confirmed his wandering could have led to other resident's items being taken and could have risked harm to the resident or to another resident.

An interview with the Administrator on 4/7/22 at 4:55 PM, revealed the residents have the right to be able to enjoy the common areas of the facility, but residents should not go into other residents' rooms uninvited. She confirmed the facility has the responsibility to ensure a resident does not wander into another resident's room. She confirmed the need to keep residents safe and free of someone coming into their rooms and this resident should have been monitored closely.

Record review of Social Services Plan of Care Note dated 3/31/2022 revealed, "Care Plan Meeting: RR (Resident Representative) did not attend. Resident is receiving long term care. No plan of discharge. Resident has exhibited wandering. Staff redirects. Will continue to monitor."

Record review of Resident #46's Admission Record revealed the resident was admitted to the facility on 1/26/2016. Diagnoses include Metabolic Encephalopathy, Cognitive Communication Deficit, Dementia, and Conduct Disorder.

Record review of Minimum Data Set dated 12/26/2021, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 655	Continued From page 21	M 655		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to label and date a tube feeding for one (1) of four (4) residents observed. Resident #5 Findings Include A review of the facility policy titled, "Labeling of Enteral Feeding Supplies/Containers" with a revision date of 4/20/19 revealed, "It is the policy of this facility that all enteral feeding bottles/bags will be labeled with the rate of feeding, date bottle/bag began and initials of the nurse initiating as well as the feeding formula listed". An observation on 04/04/22 at 11:38 AM, revealed Resident #5 had a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube connected to a continuous feeding pump. This observation revealed a bottle of Osmolite formula connected to the resident's feeding pump running at 70 milliliter per hour (ml/hr.) with no date/time, resident name, room number(#) or flow rate of feeding labeled on the Osmolite bottle.	M 655	Resident #5 had tube feeding changed and a new bottle began with proper label on 4/4/22. Policy for Gastric Tube Feeding via continuous pump was updated by the Director of Clinical Operations on 4/20/22. All enteral tube feeds were checked for proper labeling by the registered nurse supervisor on 4/7/22. All tube fed residents have the potential to be affected by this deficient practice. The Director of Nursing completed in-servicing of all licensed nursing staff on labeling of tube feeding on 4/28/22. The Director of Nursing or Registered Nurse Supervisor will audit four (4) tube feedings per week x two (2) months for proper labeling beginning 5/2/22. Observations will be reviewed by the Quality Assurance Committee monthly x two (2) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.	5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 655	Continued From page 22 An observation on 04/04/22 at 03:35 PM, revealed no date/time, resident name/room number or feeding flow rate on the Osmolite formula bottle connected to Resident #5's PEG tube that was running at 70 ml/hr. via pump. An interview on 4/5/22 at 5:00 PM with Licensed Practical Nurse (LPN) #1 revealed that when she hangs a new tube feeding that she is supposed to label it with the resident's name, room #, date and time it was started and the milliliters/hour (ml/hr). If she finds a tube feeding that is not labeled, then she is supposed to hang a new one. She revealed that all this information is written on the tube feeding to let the next nurse know when it was done. She revealed that she was not Resident #5's nurse, but she found another resident's feeding tube not labeled yesterday. An interview on 4/5/22 at 5:08 PM with Registered Nurse (RN) #2 confirmed that when a new feeding tube bottle is hung and attached to a resident's feeding pump then the date and time it is hung, flow rate, resident's name and room number should be written on the formula bottle. An interview on 4/7/22 at 9:22 AM, with LPN #2 revealed she worked 7 AM to 3 PM shift Monday 4/4/22 and she should have caught the fact that Resident #5's feeding tube bottle was not dated or labeled and corrected it. An interview on 4/7/22 at 10:45 AM, with the Director of Nurses (DON) confirmed that when a new feeding tube bottle is hung, it should be labeled with the resident's name, room number, date, and time. The DON revealed that the reason for labeling the feeding tube bottle is to ensure it is the correct resident, formula type and dose. The DON revealed that the date and time	M 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 655	Continued From page 23 being labeled on the feeding bottle ensures that we know when it was hung, because if it was too old then the milk could spoil and make the resident sick. The DON revealed it is the facility policy to hang a brand-new bag if they discover one that is connected but not labeled. Record review of Resident #5's Admission Record revealed an admission date of 9/29/20 with medical diagnoses of Parkinson's Disease and Dysphagia. Record review of Resident #5's "Order Summary Report" revealed an order dated 3/9/22, "Enteral Feed Order every shift for feeding to be turned off at 11 PM and turned on at 12 am every day related to Dysphagia, Oropharyngeal Phase, Feeding tube-NPO (Nothing by mouth), Head of bed (HOB) up 30-45 degrees. Osmolite @ 70 ML (milliliters) per pump ..." Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/21, Section K revealed the resident is receiving tube feedings. Section C revealed a Brief Interview for Mental Status (BIMS) score of 02, which indicates the resident is severely cognitively impaired.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Widespread	M 815	On April 4, 2022, the Dietary Manager	5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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) COMPLETE DATE
M 815	Continued From page 24 Based on observations, staff interviews, and facility policy review, the facility faied to prevent the likelihood of food contamination as evidenced by observation, during the initial kitchen tour, of improper thawing of raw chicken, for 51 of 53 residents receiving dietary trays. Findings include: Review of facility policy titled, "Thawing Food," Policy #: SI.43, Section: Sanitation and Infection Control, with originated date of 10/08, and revised date of 09/14, revealed, "Policy: The facility shall ensure that foods served to residents are thawed in a manner to prevent contamination .....Procedure: Frozen food is thawed in one of these ways: ....2. Running water .....b. Completely submerge food under running potable (drinking) water at 70 degrees or below." An observation, during the initial kitchen tour, on 04/04/22 at 10:34 AM, revealed raw chicken thawing, in one side of the deep 2(two)-compartment sink, completely submerged with no running water. The raw chicken sat at the bottom of the opposite side of the sink, that was away from the faucet. An interview on 04/04/22 at 10:35 AM, with the Dietary Department (DD) #2 (Manager), confirmed the raw chicken was being thawed in the 2-compartment sink full of water, that the chicken sat at the bottom of and on the opposite side of the sink, away from the faucet, that there was no water running over the chicken to thaw it, and that was not the proper process to be used to thaw raw chicken. DD #2 revealed that the incorrect thawing process could possibly cause Salmonella bacteria to grow, which could possibly	M 815	turned on the water over the pan of frozen raw chicken that was in sink as to "completely submerge under potable water at 70 degrees or below with sufficient water pressure to remove loose food bits into the drain". All dietary workers involved were promptly in-serviced on the facility policy titled "Thawing Foods" on April 4, 2022 by the Dietary Manager. The facility has determined that all residents who consume food by mouth have the potential to be affected. On April 11-12, 2022, the Dietary Manager in-serviced all dietary staff on the facility policy titled "Thawing Foods" to ensure the safety and quality of food. On April 5, 2022, the Dietary Manager will in-service all dietary staff monthly x3 months beginning in May 2022, on hire, annually and as needed on food safety policies and precautions in accordance with professional standards for food service safety. Beginning April 8, 2022, the Dietary Manager will monitor dietary staff for proper thawing procedures weekly x3 months or until consistent substantial compliance is met to ensure food safety. Beginning May 12, 2022, the Dietary Manager will bring any adverse findings to the monthly Quality Assurance Committee meeting x 3 months for a period of three (3) months or until such time consistent substantial compliance has been met. Any issues found will be discussed for further recommendations and oversight.	

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	25BN	A. BUILDING: _____ B. WING _____	04/07/2022

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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M 815	Continued From page 25 lead to sickness for the residents. DD #2 (Manager) revealed she had not conducted any in-services with the dietary staff pertaining to proper thawing of foods. An interview, on 4/7/22 at 09:00 AM, with DD #1, revealed she was thawing the raw chicken out and was not using the correct thawing process. DD#1 revealed she would normally put raw meat in a deep pan, and then place the deep pan of raw meat under cool running water to thaw. DD #1 revealed not thawing the raw chicken correctly could possibly cause the residents to get Salmonella or food poisoning of some kind. An interview on 4/7/22 at 11:30 AM, with the Administrator, confirmed the residents could possibly get Salmonella poisoning due to the dietary staff not using the correct thawing process to thaw out the raw chicken.	M 815		
M 945	45.32.4 Food Storage Food Storage. A food-storage room with cross ventilation shall be provided. Adequate shelving, bins, and heavy plastic or galvanized cans shall be provided. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water leakage, or any other source of contamination. The food-storage room should be adjacent to the kitchen and convenient to the receiving area. The minimum area for a food-storage room shall equal two and one-half (2 1/2) square feet per bed and the width of the aisle shall be a minimum of three (3) feet. This Statute is not met as evidenced by: Level II Widespread	M 945	On April 4, 2022, the Dietary Manager	5/31/22

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M 945	Continued From page 26 Based on observations, staff interviews, and facility policy review, the facility failed to dispose of three (3) and one-half (1/2) loaves of expired sliced sandwich bread, for 51 of 53 residents receiving dietary trays. Findings include: Review of facility policy titled, "FOOD STORAGE LABELING.....Policy #:FP.1.....Section - Food Storage..... Originated 10/08.....Revised 2/15,10/17," revealed Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures.....i. Identify the food item's use by date or expiration date....ii. Store items with the earliest use-by or expiration date in front of items with later dates.....iii. Use items stored in front first.....iv. Foods stored in storage units will be surveyed routinely to identify and discard food that have passed it manufacturer use-by-date or expiration date. Suggested time frames: 1. Dry Storage - Weekly." An observation, during the initial kitchen tour, on 04/04/22 at 10:34 AM, revealed three (3) full loaves of sliced sandwich bread and one-half (1/2) loaf of sliced sandwich bread with an expiration date of March 16, 2022. An interview on 04/04/22 at 10:35 AM, with the Dietary Department (DD) #2 (Manager), revealed she did not know the 3 ½ loaves of sliced sandwich bread was expired. There was no specific dietary employee assigned to ensure bread was disposed of after the expiration dates. It was the responsibility of all dietary staff to monitor the bread for expiration dates. DD #2 revealed the process for usage of the bread was	M 945	immediately discarded the three (3) and one-half (1/2) loaves of bread that were expired. All dietary workers involved were promptly in-serviced on April 4, 2022 on the facilities "Food Storage Labeling" policy by the Dietary Manager. The facility has determined that all residents who consume food by mouth have the potential to be affected. On April 11-12, 2022, all dietary staff were in-serviced by the Dietary Manager on the facilities policy "Food Storage Labeling" to ensure the safety and quality of food. On April 5, 2022, the Dietary Manager assigned the duty of checking for expired food weekly, every Tuesday, to the evening aide on duty. The Dietary Manager will in-service all dietary staff monthly x3 beginning in May 2022, on hire, annually and as needed on "Food Storage Labeling" in accordance with professional standards for food service safety. Beginning April 8, 2022, the Dietary Manager will monitor dietary staff weekly x3 months or until consistent substantial compliance is met to ensure food safety. The Dietary Manager will bring any adverse findings to the Monthly Quality Assurance Committee meeting x3 months to assure substantial compliance. Any issues found will be discussed for further recommendations and oversight.	

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M 945	Continued From page 27 to stack the oldest bread on the top of all the bread in storage to be used first, before the expiration date. She confirmed the expiration date of March 16, 2022, was on the 3 ½ loaves of sliced sandwich bread. DD#2 revealed the bread could have possibly molded from being kept and used past the expiration date and could possibly cause the residents to be contaminated with whatever bacteria that could have possibly grown on the sliced sandwich bread. DD #2 revealed that sandwiches were made every evening and are sent to the nursing units to be used as part of the Diabetic residents' evening snack. DD #2 (Manager) revealed there had not been any in-services done by her with the dietary staff pertaining to proper storage/disposal of expired foods. An interview, on 4/7/22 at 11:30 AM, with the Administrator confirmed there was a possibility of growth of bacteria on the sliced sandwich bread that expired on March 16, 2022, which could possibly cause some form of illness to the residents.	M 945		
M1230	45.40.11 Call System Call System. A call system shall be in place at the nurses' station to receive resident calls through a communication system to include audible and visual signals from bedrooms, toilets, and bathing facilities. This Statute is not met as evidenced by: Level II Widespread Based on observations, staff interviews, record reviews, and facility policy review the facility failed to provide a sufficient volume level on the	M1230	On April 7, 2022, the Administrator increased the call light system monitor's volume, located at the 200 Hall nurse's station desk from medium to high allowing staff to hear call lights to the end of	5/31/22

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M1230	Continued From page 28 resident call light system as evidenced by the inability to hear the call light system alarm on the nursing unit halls for four (4) of 4 days of survey. Findings include: Review of the facility policy title, "Call Light, Answering," undated, revealed "Purpose - The purpose of this procedure is to respond to the resident's requests and needs..." An observation on 4/4/22 at 10:30 AM, revealed the call light globes, located above the resident room doors would light up when the call light system was activated, but no call light system alarm was heard on the nursing unit halls to alert the staff that the call light was activated. The call light system monitor was located at the 200 Hall nurse's desk and all the resident calls for assistance for the 100 Hall, for the 200 Hall, and for the 300 Hall, were to be answered through that one (1) call light system monitor. The State Agency (SA) was able to hear the call light system alarm while at the nurse's desk, which was at a low volume, but could not hear the call light system alarm at one of the closest resident rooms, #201, which was approximately 20-25 feet away from the 200 Hall nurse's station desk. The State Agency walked down to the end of the 100 Hall, which was approximately 40-50 feet away from the 200 Hall nurse's desk, walked down to the end of the 200 Hall, which was approximately 40 to 50 feet away from the 200 Hall nurse's station, and walked down to the nurse's station on the 300 Hall, which was approximately 30-40 feet away from the 200 Hall nurse's station, and was not able to hear the call light system alarm. An interview on 4/5/22 at 04:35 PM, with Registered Nurse (RN)#2 revealed that some	M1230	residents' halls. All residents residing in rooms where call lights could not be heard had the potential to be affected. On April 7-14, 2022, the Administrator in-serviced all staff on maintaining the call light system monitor's volume on high at all times. On April 8, 2022, the Administrator placed a sign by the call light system monitor stating that the volume of call lights must be maintained at high at all times and that the Administrator was to be notified immediately of any issues with the call light system monitor. Beginning on April 8, 2022, the Administrator will monitor the call light system monitor's volume daily, Monday through Friday, for (30) thirty days. The administrator will immediately address any issues. All issues will be brought to the Weekly Quality Assurance Committee by the Administrator for further recommendations and oversight.	

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M1230	Continued From page 29 nursing staff members had revealed to her as the RN Supervisor that they could not hear the call light system alarm if they were not directly at the nurse's station. RN #2 also revealed that there was not a staff member assigned to the desk to be able to monitor the call light system at all times. RN #2 revealed not being able to hear the call light system alarm was a problem the facility staff had been dealing with for a while but could not reveal how long the problem had existed. RN #2 revealed a verbal report had been made to the higher-level staff regarding the problem. An interview on 4/5/22 at 04:38 PM, with Certified Nurse Aide (CNA)#5, who was located behind the 300 Hall nurse's desk revealed that the CNA staff had expressed to her, as the Lead CNA, they are not able to hear the call light system alarm on the 100 Hall, 200 Hall, or the 300 Hall. CNA #5 revealed she could not hear the call light system alarm while she sat at the nurse's desk on the 300 Hall, and could only hear the call light system alarm when she stood at the 200 Hall nurse's station desk. CNA #5 revealed she had instructed the CNA staff to look up at the globes over the residents' rooms to see if a call light was on when they were out on the halls. An interview on 4/6/22 at 09:40 AM, with the Director of Nursing (DON), revealed the call light system alarm volume was too low to be heard down the nursing unit halls from the 200 Hall nurse's desk. The DON revealed the call light system alarm volume being down that low could possibly cause a call light not to be answered timely. An interview on 4/7/22 at 09:25 AM, with CNA #9 who was located on the 300 Hall, revealed she was not able to hear the call light system alarm	M1230		

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M1230	Continued From page 30 when out on the nursing unit. CNA #9 revealed she could hear the alarm if she stood at the 200 Hall nurse's station desk. An interview on 4/7/22 at 09:29 AM, with CNA #10 who was located on the 300 Hall, revealed she was not able to hear the call light system alarm when she was away from the 200 Hall nurse's station desk. An interview on 4/7/22 at 09:34 AM, with RN #1 who was located on the 100 Hall, revealed she cannot hear the call light system alarm when away from the 200 Hall nurse's station desk. An interview on 4/7/22 at 12:30 PM, with Licensed Practical Nurse (LPN) #4, who was located on the 300 Hall, revealed she cannot hear the call light system alarm on the 300 Hall, because the call light system's volume was too low to hear from the 200 Hall nurse's station desk. An interview on 4/7/22 at 12: 35 PM, with CNA #11, who was located on the 300 Hall, revealed she could not hear the call light system alarm when she was on the 300 Hall. An observation and interview on 4/7/22 at 03:25 PM, with the Administrator revealed the Administrator increased the call light system monitor's volume, located at the 200 Hall nurse's station desk from medium to high. The SA went down the 200 Hall to listen for the call light system alarm's sound. The call light system alarm sound could be heard down to the end of the 200 hall, 40-50 feet away from the 200 Hall nurse's station desk, due to the increased volume. The Administrator also walked down the 200 Hall, past room #212, approximately 30 feet from the	M1230		

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M1230	Continued From page 31 200 Hall nurse's station desk, confirmed she was able to hear the call light system alarm. She revealed she had assigned the RN Charge Nurses to stay at the nurse's desk to monitor the call light system alarm and inform staff when a resident needed assistance but revealed there was not a written schedule for the assignment. The Administrator revealed that the call light system volume was low because she thought the high volume was too much noise. The Administrator revealed the call light system volume not being heard by the nursing staff could have possibly caused residents call lights not to be answered in a timely manner.	M1230		