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 **04/13/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation, Complaint 2965461 and Complaint (Incident) 2961832 at the facility on 4/13/26. Both were investigated related to misappropriation, medication storage and medication administration. During the survey, SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500.	M0000		
M0500	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; 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	M0500		

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

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M0500	Continued from page 1 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 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;	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, facility policy review, and staff and resident interviews, the facility failed to prevent the misappropriation of property, specifically scheduled medication, for one (1) of four (4) sampled residents, Resident #1. Findings Included: Record review of the facility's Abuse Policy and Procedure with Review/Revision Date 1/24/22 revealed, "Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment, neglect and or misappropriation of resident property…7. 'Misappropriation of resident property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...". On 4/13/26 State Agency (SA) conducted an investigation for complaint 2965461 and facility reported Incident 2961832 at the facility related to misappropriation of medication, medication administration and medication storage. Record review of the Facility Investigation dated 3/23/26 revealed that on 3/19/26 it was discovered during shift change by LPN (Licensed Practical Nurse) #2 and LPN #3 that Resident #1's medication, Clonazepam, was tampered with two (2) tablets removed from their blister pack and replaced with two (2) unidentified tablets. The tampered with blister pack that contained the unidentified tablets was delivered to the former Director of Nurses (DON) who replaced the blister pack with the unidentified tablets taped inside back in the Narcotic Lock box in the Medication Cart. According to the facility's investigation, all three nurses that had access to the 100 Hall medication lock box submitted to drug tests and the facility was unable to determine how or when or by whom the blister pack had been tampered with and the blister pack that had been tampered with and the remaining tablets therein were destroyed on 3/20/26 and the medications were replaced. The Facility Investigation included a printed	M0500		

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M0500	Continued from page 4 statement dated 3/23/26 and signed by LPN #2 confirmed that “the resident’s medication card contained incorrect medications”. Record review of the Controlled Drug Package Inventory log for the medication cart for the 100 Hall dated 3/14/26 through 3/20/26 revealed that on 3/20/26 one (1) package that contained thirteen (13) doses (tablets) of Clonazepam 2 mg (milligrams) that belonged to Resident #1 was removed from the 100 Hall Medication Cart Narcotics Locked Box. Record review of the Controlled Drug Record with delivery date 3/06/26 revealed Resident had forty-two (42) Clonazepam 2 milligram tablets, with description included as “This medicine is a white, round-shaped, scored tablet imprinted with a 2”, delivered to the facility for Resident #1. According to the Record, tablet number 17 was administered to Resident #1 by LPN #1 and tablet number 16 was wasted on 3/20/26 by the Staff Development Nurse. Record review of the Drug Wastage Destruction Log for controlled Substances dated 2/04/24 through 3/20/26 revealed that on 3/20/26 there was one (1) “incorrect med” for Resident #1 was destroyed by the Staff Development Nurse. Record review of the Order Summary Report with active orders as of 4/13/26 for Resident #1 revealed she had a physician’s order for Clonazepam 2 milligram tablet, one (1) tablet by mouth three (3) times a day related to essential tremor. During an interview the Administrator on 4/13/26 at 11:30 AM revealed the facility had investigated and reported to appropriate agencies the misappropriation of two (2) 2 milligram Clonazepam tablets belonging to Resident #1 on 3/23/26. He explained that on 3/19/26, LPN #2 and LPN #3 conducted narcotics accountability count for the locked narcotics box on the 100 Hall medication cart at approximately 7:00 AM during shift change, realized that Resident #1’s blister pack of Clonazepam 2 milligram tablets had been tampered with as the foil back of tablets numbers 16 and 17 had been punctured, and it was determined that there were unidentified tablets in the blister package in the damaged blisters. He confirmed that all three (3) of the nurses that had access most recently to the narcotics locked box on the 100 Hall medication cart submitted to drug tests and that the facility could not determine when or by whom the blister pack had been tampered with. He confirmed that the resident had been assessed following the discovery and determined to have	M0500		

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M0500	Continued from page 5 no adverse effects and she was her own resident representative and her primary healthcare provider was notified with no new orders notes. He stated that the facility investigation did not result in determination of who had damaged the package, taken the resident's prescribed, scheduled medication, or replaced the missing tablets with unidentified tablets. On 4/13/26 at 12:45 PM an interview and observation with Resident #1 revealed she had essential tremors and was prescribed Clonazepam for the tremors for approximately thirty (30) years. She stated she felt safe at the facility and that having not received one dose of her Clonazepam had not affected her to the best of her knowledge. She stated she had constant tremors with or without the Clonazepam. The resident was neat, clean, well-groomed, appropriately dressed and seated in her wheelchair with good posture and constant nodding of her head and shaking hands. She said that she appreciated the facility's addressing the incident in an appropriate manner and that she had not had any adverse reaction from the medication error. Record review of the Controlled Drug Record for Resident #1's Clonazepam 2 MG (milligram) tablets revealed that on 3/06/26 forty-two (42) tablets had been delivered to the facility from the pharmacy. Record review of the Controlled Drug Package Inventory sheet for the 100 Hall revealed that on 3/20/26 a blister pack that contained thirteen (13) tablets of Klonopin (clonazepam) 2 MG for Resident #1 was removed from the 100 Hall medication cart locked narcotics box. Record review of the Drug Wastage Destruction log for Controlled Substances revealed that on 3/20/26 thirteen (13) tablets of Klonopin (clonazepam) 2 MG for Resident #1 were destroyed per facility policy and procedure. On 4/13/26 at 1:30 PM during interview LPN #3 confirmed that he had been on duty on the 100 Hall on the dayshift (7:00 AM through 3:00 PM) on 3/19/26 and that during the narcotics accountability count of the scheduled medications in the locked box in the 100 Hall medication cart he noted that the foil seal on the back of the blister pack of Resident #1's clonazepam had been punctured. He stated that upon further investigation it appeared that tablet #16 and tablet #17 had been replaced with two (2) unidentified tablets. He said that he and LPN #2 had reported the discovery to the Director of Nursing and the Administrator on the morning of 3/19/26. On 4/13/26 at 2:00 PM an interview with the Staffing	M0500		

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M0500	Continued from page 6 Coordinator revealed she had participated in the facility investigation into the misappropriation of two (2) clonazepam tablets that belonged to Resident #1. She confirmed that she had administered drug test to the nurses responsible for the safekeeping of the 100 Hall medication cart and narcotics locked box therein; she reported that the facility was not able to determine when or by whom Resident #1's clonazepam was tampered with. On 4/13/26 at 2:15 PM during interview the DON confirmed that on 3/19/26 nursing staff determined that two clonazepam 2 milligram tablets that belonged to Resident #1 had been misappropriated and replaced with two unidentified tablets. Record review of the Admission Record for Resident #1 revealed the facility admitted her on 2/09/26 and she had diagnoses of myasthenia gravis, abnormalities of gait and mobility and lack of coordination. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 2/15/26 for Resident #1 revealed that the facility assessed her Brief Interview for Mental Status score as 13, which indicated no cognitive impairment.	M0500		