STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with two (2) Complaint Investigations (CI MS #2985748 and CI MS #2988845), at the facility from 4/27/26 to 4/30/26. CI MS #2985748 was investigated related to staffing, housekeeping, and residents left wet and soiled and there were no deficiencies related to that CI. MS #2988845 was a Facility Reported Incident (FRI) regarding physical abuse and F600 was cited, however, based on the implementation of the facility's corrective actions on 04/22/2026, the deficient practice was determined to be Past Non-Compliance (PNC) as of 04/23/3036 for F600. During the recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F700 and F880. The facility held a license for 95 beds and had a current census of 93.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by:	F0600	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = G	Continued from page 1 Based on interview, record review and facility policy review, the facility failed to ensure the resident's right to be free from abuse for one (1) of (20) sampled residents. Resident # 53 Findings include: Record review of facility policy; “Abuse Policy and Procedure” , revision date April 2021 revealed, “Residents have the right to be free from abuse… Policy interpretation and implementation: The resident abuse, neglect and exploitation prevention program consist of facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse… by anyone including but not necessarily limited to: a. facility staff...” Record review of the facility investigation dated 4/21/26 revealed on 4/17/26 CNA # 1, Certified Nurse Aide (CNA), reported to Licensed Practical Nurse (LPN) # 4, that Resident #1 had a bruised left eye. Review revealed CNA # 1 reported the injury may have occurred while pushing Resident #53 to the dining table due to the resident’s short, stooped posture. Record review further revealed the CNA reported Resident #53 used a racial slur toward her and she verbally responded but denied striking the resident. During an interview on 04/27/2026 at 11:30 AM, with Resident #53 she was unable to recall the incident in question. During an interview on 04/28/2026 at 2:00 PM, LPN #4 stated Resident #53 reported being hit in the eye by CNA #1. LPN#4 stated CNA # 2 reported she heard a commotion but did not witness the incident. She stated that when CNA #2 observed the resident’s injury and asked what happened, Resident #53 reported she struck CNA #1 and was struck back in the eye, while making a motion consistent with a slap. She stated the resident provided a similar account to her. LPN # 4 revealed she reported the incident and removed CNA #1 from the unit with instructions not to return. During an interview on 04/28/2026 at 2:45 PM, CNA #2 stated she heard a commotion and later observed bruising to Resident #53’s left eye. She stated that when she asked what happened, Resident #53 reported she hit CNA #1 and was hit back in the eye, while making a motion consistent with a slap. During an interview on 04/29/2026 at 11:00 AM, the Social Services Director stated she interviewed	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = G	Continued from page 2 Resident #53 to assess psychosocial status following the incident. She reported the resident voiced no complaints and stated she felt safe. She stated the resident did not recall the incident, which she attributed to advanced dementia. She stated all residents assigned to the staff member involved were interviewed to assess any concerns related to abuse, neglect, or exploitation. She reported no additional allegations or concerns were identified. She stated she will continue to monitor Resident #53 for any changes in mood, behavior, or psychosocial well-being and will follow up as needed. During an interview on 04/29/2026 11:15 AM, the Director of Nurses (DON) revealed that following the investigation, it was determined that CNA # 1 struck Resident # 53 in the eye. She stated the staff member was removed from duty during the investigation and was subsequently terminated once the allegation was substantiated. The Administrator stated Resident # 53 was assessed by nursing the following day. On 04/21/2026, an emergency Quality Assurance and Performance Improvement meeting was conducted upon determination that abuse occurred. She stated Social Services interviewed the resident to assess psychosocial status. The resident voiced no additional complaints and did not recall the incident, which was attributed to advanced dementia. She further revealed that all residents assigned to CNA #1 were interviewed by Social Services, and no additional concerns were identified. The Resident Representative was notified by the Administrator and Director of Nursing regarding the investigation findings and cause of the injury. The Administrator stated a report was filed with the county police department. Written reports were submitted to the State Agency and the Attorney General's Office. She reported all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using Centers for Medicaid and Medicaid Services (CMS) Hand in Hand Module 5, as well as crisis intervention and de-escalation tools. She stated a memo was posted at the time clock directing staff to complete training at the start of their shift, and designated staff monitored compliance. All staff completed the required training by 04/22/2026. During an interview on 04/29/2026 at 11:38 AM, the Licensed Nursing Home Administrator (LNHA) stated that following the facility investigation, it was determined that CNA # 1 struck Resident #53 in the eye. He stated the staff member was immediately removed from duty during the investigation and was terminated upon confirmation of the allegation. He	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = G	Continued from page 3 stated it was his decision to make the final determination to terminate CNA #1 even though it was not witnessed. He stated the resident was assessed by nursing the following day. He reported that on 04/21/2026, once the allegation was substantiated, the facility conducted an emergency Quality Assurance and Performance Improvement meeting. He stated Social Services interviewed the resident to assess psychosocial status. He reported the resident voiced no additional concerns and did not recall the incident, which he attributed to advanced dementia. He further stated all residents assigned to CNA #1 were interviewed by Social Services, and no additional concerns were identified. He confirmed the Resident Representative was notified by the Administrator and Director of Nursing regarding the findings of the investigation. He stated a report was filed with the county police department and written reports were submitted to the State Agency and the Attorney General's Office. He stated all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using CMS Hand in Hand Module 5, as well as crisis intervention and de-escalation techniques. He reported a memo was posted at the time clock directing staff to complete the training at the beginning of their shift, and staff compliance was monitored. He confirmed all staff completed the required training by 04/22/2026. Record review of the "Face Sheet" revealed Resident # 53 was admitted 11/20/25 to the Memory Care Unit with diagnoses including Alzheimer's disease, cognitive communication deficit, and unspecified dementia with behavioral disturbance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. Record review of the Social Services progress note dated 4/21/26 at 12:31 PM, revealed Social Services and the Assistant Administrator followed up with Resident #53 upon her return from a supervised joy ride and after lunch to assess emotional and psychosocial status related to the alleged abuse incident. Documentation revealed when asked how she was doing and if everything was going okay, Resident #53 stated, "It's good." When asked if she felt safe, the resident responded, "Yes." Record review revealed the resident was documented to be in a good mood, voiced no concerns, and expressed no issues at the time of the follow up.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = G	Continued from page 4 Record review of the facility's abuse investigation concluded Resident #53 did not sustain the injury by accidentally striking the dining table and the facility determined that CNA # 1 struck Resident #53 in the eye. CNA # 1 was suspended pending investigation and subsequently terminated. The facility reported the allegation to the State Agency, the Attorney General's Office, and local law enforcement. The facility conducted an emergency Quality Assurance Performance Improvement (QAPI) meeting, notified the Resident Representative, interviewed additional residents assigned to CNA #1 and educated staff regarding abuse prevention, resident rights, recognizing burnout, and preventing abuse. Record review of the progress note dated 4/17/26 at 1:39 AM revealed acute follow up assessment related to left orbital ecchymosis from an injury identified on the prior shift. Documentation revealed a dark red circular bruise to the left eye region, dark purple bruising along the lateral bridge of the nose extending to the superior left cheek, tenderness on palpation, minimal edema, and complaint of pain with the resident stating, "It's sore." The residents' pupils were equal, round, and reactive to light and accommodation. Documentation noted due to advanced Alzheimer's disease, the resident was unable to reliably express symptoms such as blurred vision, double vision, dizziness, or headache, however nursing documented no apparent visual disturbance at that time. Interventions included staff assistance with transfers and toileting for safety, head of bed elevated to 45 degrees to reduce bruising, application of cold compresses to the eye area twice for ten minutes to reduce edema, and continued monitoring. Documentation revealed no acute distress, respirations even and unlabored, skin warm and dry, and resident resting quietly in bed. Vital signs were documented as temperature 97.5, pulse 79, respirations 16, and blood pressure 121/67. Further documentation revealed continued treatment and monitoring were implemented.	F0600		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 5 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 6 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility policy review and record review, the facility failed to ensure staff followed infection prevention and control practices to prevent the spread of infection during resident care for two (2) of five (5) care observations. Resident #2 and Resident #82 Findings Include: Record review of the facility policy “Policy for Handwashing” undated, revealed, “Objective: To prevent and to control the spread of infectious disease.1. Appropriate 15 second hand washing with antimicrobial soap and water must be performed under the following conditions: a. when hands are visibly dirty or soiled with blood or other body fluids; b. after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; c. after handling items potentially contaminated with blood, body fluids, or secretions; d. before eating; e. after using a restroom...3. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. before direct contact with residents…f. after removing gloves. Record review of the facility policy “Enhanced Barrier Precautions” (EBP) dated 8/2022 revealed, “… EBP are used as an infectious prevention and control interventions to reduce the spread of multi-drug-resistant organisms (MDROs) to residents... 2.a.Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room)…5. EBP are indicated (when contact precautions do not otherwise apply) for residents with wounds and or indwelling devise regardless of MDRO colonization...9. Staff are trained prior to caring for residents on EBP’s...” Resident # 2:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 7 In an interview with resident #2 at 2:08 PM on 4/28/26, he stated that he had been dealing with a urinary tract infection (UTI) in the past month requiring treatment with antibiotics. On 04/28/2026 at 2:17 PM, Registered Nurse (RN) #1 was observed performing catheter care. During the procedure, the nurse dropped a washcloth onto the bed linen, retrieved it, and used the same contaminated washcloth to cleanse the catheter site. The nurse then touched the bathroom door handle while wearing contaminated gloves after completing care. During an interview on 04/28/2026 at 2:21 PM, RN #1 stated she should have discarded the washcloth once contaminated and performed hand hygiene after removing gloves before touching environmental surfaces. She confirmed her actions created a risk for cross contamination. During an interview on 04/29/2026 at 2:31 PM, the Director of Nursing (DON) stated the nurse should have discarded the contaminated washcloth and performed hand hygiene after glove removal. She confirmed staff are expected to follow infection prevention policies. During an interview on 04/30/2026 at 11:01 AM, the Infection Preventionist (IP) stated proper catheter care requires discarding contaminated supplies and performing hand hygiene after glove removal to prevent cross contamination. Record review of the “Face Sheet” revealed Resident # 2 was admitted to the facility on 6/14/22 with a diagnoses that included central cord syndrome. Record review of the Minimum Data Set (MDS) section C with an Assessment Review Date (ARD) of 4/14/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. Record review of the “Physician Order Report” dated 3/28/26-4/28/26 revealed an order dated 2/10/25 “Record catheter output q (every) shift.” Resident # 82: On 04/28/2026 at 3:20 PM, Licensed Practical Nurse (LPN) #1 was observed administering medications via Percutaneous Endoscopic Gastrostomy (peg) tube to Resident #82. The nurse entered the room and donned (put on) gloves without performing hand	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 8 hygiene. While wearing the same gloves, the nurse touched multiple surfaces including the faucet, medication cart, computer mouse, privacy curtain, and bed controls prior to initiating care. The nurse did not don a gown. The nurse administered medications via peg tube without changing gloves or performing hand hygiene during the process. After completing the procedure, the nurse removed gloves and exited the room without performing hand hygiene. During an interview on 04/28/2026 at 3:40 PM, LPN#1 stated she had not received training on Enhanced Barrier Precautions (EBP) and acknowledged she failed to perform hand hygiene, wear a gown, and change gloves. She confirmed this created a risk for cross contamination. During an interview on 04/29/2026 at 3:12 PM, the IP stated LPN #1 had not completed required infection control training. She stated the nurse should have performed hand hygiene upon entry, worn a gown, and changed gloves after contact with environmental surfaces. She confirmed the observed practice exposed the resident to infection risk. During an interview on 04/29/2026 at 3:38 PM, the DON stated LPN#1 should have completed required training, performed hand hygiene, and worn a gown during peg tube medication administration. She confirmed failure to follow these practices increased the risk of infection. Record review of Resident #82 "Face Sheet" revealed an admission date of 11/11/20 with diagnoses that included Hemiplegia, unspecified affecting right dominant side and cerebral palsy, unspecified. Record use of the “Physician Order Report” revealed orders dated 6/6/23 for Calcium 500 plus D (calcium carbonate-vitamin d), phenobarbital 64.8 mg (milligrams) and an additional order dated 7/24/25 for phenytoin tablet chewable via peg tube. Record review of the MDS with an ARD of 2/23/26 revealed a BIMS score of (3) indicating the resident had severe cognitive impairment.	F0880		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = D	Continued from page 9 alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure other alternatives were implemented prior to the installation of bed rails and failed to assess and monitor the use of bed rails as a restraint and ensure they were medically necessary and the least restrictive intervention for one (1) of five (5) resident reviewed for restraints. Resident #42 Findings Include: Record review of the facility policy “Use of Side Rails” revealed, “ The resident should be observed and assessed daily in order to assure the maintaining of his/her practicable physical, mental, and psychosocial well-being...” Record review of the facility policy, ”Restraint Policy” undated revealed, “…It is the objective of this facility for each resident to be free from any physical restraint to maintain the highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances to which the resident has medical symptoms that warrant the use of restraints...” On 04/27/2026 at 12:26 PM, Resident #42 was observed lying in bed with both side rails in the full up position, functioning as full length side rails.	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = D	Continued from page 10 During an interview on 4/29/2026 at 1:15 PM, Licensed Practical Nurse (LPN) #2 confirmed the resident had full side rails in use. She stated she did not consider them a restraint and was unsure of the clinical justification. She reported the resident was total care and unable to reposition independently. She confirmed staff do not assess or document the side rails as a restraint and do not monitor their continued necessity. She acknowledged the rails could restrict movement and require a resident to climb over them to exit the bed. During an interview on 04/29/2026 at 1:30 PM, Registered Nurse (RN) #2 stated a pre-restraint evaluation should be completed prior to initiation but was unable to provide documentation. She stated the side rails were used at the request of the family following a prior fall. She confirmed less restrictive alternatives were not implemented prior to initiating side rails. She acknowledged risks associated with full length side rails, including entrapment and injury from attempting to climb over them. During an interview on 04/29/2026 at 2:30 PM, the Director of Nursing (DON) stated side rails were in place due to family requests to prevent falls. She confirmed the facility does not assess restraints daily and documentation is not completed each shift. She stated weekly notes are entered, but no consistent monitoring process is in place. She confirmed limited documentation of entrapment monitoring and stated failure to assess restraints appropriately could place residents at risk for injury. Record review of the physician orders revealed an order dated 4/15/25 for “Full ¾ bilateral rails to prevent leaning and falling out of bed.” Record review of the “Physical Restraint Elimination Evaluation” form revealed the form was not dated with evaluation dates but included an evaluation with numbers. The form did not have the residents’ name on it. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated severely impaired mental status. Record review of the “Face Sheet” revealed Resident # 42 was admitted to the facility on 1/9/2020 with diagnoses that included cerebral infarction (stroke).	F0700		