STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey and a complaint investigation of MS Complaint # 16017 at the facility from 07/23/19 through 07/25/19. During the annual survey, the SA determined the facility was not in compliance with Medicaid and Medicare Requirements of Participation. The SA cited deficiencies at F623, F625, F656, F657, F677, F689, and F791. The Complaint was found to be unsubstantiated with no deficiencies cited. The facility was licensed for 96 bed and had a census of 93 at the time of survey.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		8/23/19

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

Electronically Signed | 08/19/2019

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 623	Continued From page 1 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the resident and/or the resident's Responsible Party (RP)/representative, in writing, of transfers to the hospital for four (4) of four (4) residents reviewed	F 623	A. Residents #31, #50, #60 and #71 have returned from the hospital. They have not had a hospital visit since that time. An Emergency Transfer Log was emailed by Social Services to the Ombudsman	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 623	Continued From page 3 for transfer to the hospital (Resident #31, #50, #60, and #71). Findings Include: Review of the facility's "Bed-hold and Readmission Policy" revealed in part: The nursing home is required to provide written information to the resident and or the responsible party for residents transferred from the facility. Resident #71 A review of Resident #71's medical record revealed the resident had been sent to the hospital from 6/06/19 through 6/9/19, due to altered mental status. There was no evidence in the medical record of written notification of transfer to the hospital to the resident or resident's representative. Resident #31 On 07/24/19 at 9:46 AM, an interview with Resident #31 revealed she had a recent hospital stay. A review of the physician's orders for Resident #31 confirmed a transfer to the hospital on 6/2/19 and 6/9/19 for vomiting of blood. A review of Resident #31's medical record revealed no indication of written notice being given to the resident or resident's representative of transfer to the hospital. On 7/24/19 at 2:00 PM, an interview with Licensed Social Worker (LSW) confirmed Resident #31 was transferred to the hospital two (2) times in the month of June (2019) and no written notice was sent to the responsible party informing them of the transfer.	F 623	August 7th that included all transfers for the month of July. B. Ninety three (93) residents on the day of survey had the potential to be affected by the deficient practice. Seven (7) residents have been transferred to the hospital since survey, and a copy of the Bedhold Agreement was mailed to each Responsible Party. C. A new Notice of Resident Transfer form was ordered from a Medical Form Company. It was received 8/19/19 and is currently in use. On 8/20/19 the Administrator will inservice Social Services and Medical Records that when a resident is transferred, the new Notice of Resident Transfer form should be sent to the resident and/or Responsible Party as soon as practicable, at least by the next business day in order to notify in writing of the transfer and their rights. Once the form is completed and ready to be sent, a copy shall be placed in a log book, with a signed log by Social Services or Medical Records along with two witnesses for documentation. Any notices that are signed and returned shall be attached in the log book. An Emergency Transfer Log will be emailed to the Ombudsman by the 10th of the month for the preceding month by the Social Worker. D. The Director of Nursing will inspect the log book on 8/20/19 and monthly for three (3) months and compare it to the census to ensure all parties were appropriately notified. Any problems will be reported at least quarterly to the Quality Assurance Committee to make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 623	Continued From page 4 On 7/25/19 at 8:14 AM, an interview with the Director of Nursing (DON) confirmed no written notice was sent to Resident #31's Responsible Party when the resident was transferred to the hospital. Resident #60 A review of nurse's notes for Resident #50 revealed the resident had transferred to the hospital on 05/25/19, and on 07/01/19. A review of Resident #50's medical record revealed no documentation that the resident and/or the resident representative was notified in writing of the transfers to the hospital. Resident #60 A review of Resident #60's medical record revealed the resident had been transferred for acute care stays to the hospital on 05/30/19, 06/01/19, and 06/20/19. There was no documentation that the resident or the resident representative were notified in writing of the transfers to the hospital. On 7/24/19 at 2:00 PM, an interview with the Licensed Social Worker revealed she was not aware that the facility should be sending a written notice to the responsible party when the facility sends a resident to the hospital, the reason why, where the resident was transferred, and the bed hold information. On 7/25/19 at 8:14 AM, an interview with the Director of Nursing (DON) confirmed she was unaware of the regulation for sending a written notice to the responsible party, of why the resident was being transferred and to where. The	F 623	recommendations/changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 623	Continued From page 5 DON revealed we just call the RP with transfers and the bed hold form is signed on admission.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide the bed hold policy to the resident and/or resident	F 625	A. Residents #31, #50, #60 and #71 have returned from the hospital. They have not had any bedhold days since survey date.	8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 625	Continued From page 6 representative at the time of transfer for an acute care stay for four (4) of four (4) residents reviewed for transfer to the hospital (Resident #31, #50, #60, and #71). Findings Include: A review of the facility's " Bed-hold and Readmission Policy" revealed, "The nursing home is required to provide written information to the resident and or the responsible party..." Resident #31 On 07/24/19 at 09:46 AM, an interview with Resident #31 revealed she had a recent hospital stay. Review of the Physician's Orders for Resident #31 confirmed a transfer to the hospital on 6/2/19, and 6/9/19, for vomiting of blood. A review of Resident #31's medical record revealed no indication of the bed-hold policy being provided to the resident or resident's representative upon transfer to the hospital. Resident #50 A review of nurse's notes for Resident #50 revealed the resident had transfers to the hospital on 05/25/19, and on 07/01/19. A review of Resident #50's medical record revealed no indication that the resident and/or the resident representative were notified of the bed-hold policy at the time of transfers to the hospital. Resident #60 A review of Resident #60's medical record revealed the resident had been transferred for acute care stays to the hospital on 05/30/19, 06/01/19, and on 06/20/19. There was no	F 625	B. Ninety three (93) residents on the day of survey had the potential to be affected by the deficient practice. Seven (7) residents have been transferred to the hospital since survey, and a copy of the Bedhold Agreement was mailed to each Responsible Party. C. The Administrator inserviced Social Services and Medical Records on 08/20/19 that when a resident leaves the facility for hospital or therapeutic leave, a copy of our bed hold policy shall be sent to the resident and/or responsible party as soon as practicable, at least by the next business day. A log book shall be kept of when the policy was sent. This log book shall be signed by the Social Worker or Medical Records each time the policy is sent out along with two witness signatures. D. The Director of Nursing reviewed the log book on 8/20/19 and will do so monthly for three (3) months to compare the log book with the census to ensure all parties were appropriately notified. Any problems noted will be reported to the Quality Assurance Committee for recommendations/changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 625	Continued From page 7 indication that the resident and/or the resident representative were notified of the bed-hold policy at the time of transfers to the hospital. Resident #71 A review of Resident # 71's medical record revealed the resident had been sent to the hospital from 06/06/19 through 6/9/19, due to altered mental status. There was no evidence in chart of notification in writing of the bed-hold notice to the resident or resident's representative. On 7/24/19 at 2:00 PM, an interview with the Licensed Social Worker (LSW) revealed she was not aware that the facility should be issuing the bed hold policy to the resident and/or resident representative at the time of transfer. The LSW stated the bed-hold policy was signed at admission but was not being signed upon transfer. On 7/25/19 at 8:14 AM, an interview with the Director of Nursing (DON) confirmed she was unaware of the regulation to provide the bed-hold policy at the time of transfer for an acute care stay. The DON stated the bed-hold policy is only being signed on admission.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 8 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop the comprehensive care plan to address dental concerns for Resident #59; change in condition after hospitalization for Resident #31;	F 656	A. 1. Resident #59's care plan was updated on 07/25/19 by the Minimum Data Set Assessment Nurse to include yearly dental exams. Resident #59 went to the dentist on 08/08/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 9 and failed to implement the care plan related to Activity of Daily Living (ADL) care for Resident #36, #59, and #71, for four (4) of 19 sampled residents reviewed. Findings include: A review of the facility's "Care Plans - Comprehensive Person-Centered" policy, with a revision date of December 2016, revealed the policy statement "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative were to develop and implement a comprehensive, person-centered care plan for each resident. The policy further included the care plan was designed to incorporate identified problem areas and risk factors associated with identified problems. Resident #36 A review of Resident #36's Comprehensive care plan revealed a care plan with a problem/need dated 02/22/19, of "ADL's: Requires staff assistance for ADLs related to impaired mobility and cognitive impairment, The care plan had an intervention to assist with bathing, dressing, and grooming with Certified Nursing Assistant (CNA) listed as staff to complete the intervention. An observation and interview on 07/23/19 at 10:15 AM, revealed Resident #36 lying in bed watching television in her room. The resident appeared clean but had visible patches of chin	F 656	2. Resident #31's care plan was updated on 07/25/19 by Minimum Data Set Assessment Nurse to observe for vomiting and nose bleeds. Medication was ordered PRN for nausea and vomiting on 07/30/19. No vomiting or nose bleeds have been noted. 3. The care plan for Residents #36 and #59 were updated on 08/17/19 by the Minimum Data Set Assessment Nurse to include observation for and removal of facial hair. Facial hair was removed on 07/25/19 by the assigned Certified Nursing Assistant. 4. Resident #71's care plan was updated on 08/12/19 by the Minimum Data Set Assessment Nurse to include observation of fingernail cleanliness and length. The fingernails were cleaned and trimmed on 07/25/19 by the assigned Certified Nursing Assistant. B. Ninety three (93) residents on the day of the survey had the potential to be affected by the deficient practice. C. The Assessment Nurses will be inserviced on 08/20/19 by the Director of Nurses on updating the care plan to include observing facial hair and nail care and providing proper care as needed, updating the care plan on changes in condition upon returns from the hospital, and providing routine dental services. D. The Quality Assurance Nurse will audit care plans for nail care, observation and removal of facial hair, routine dental exams and all residents with hospital returns for a change of condition for a total of 30 residents monthly beginning 08/23/19 for three (3) months. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 10 hair about one (1) centimeter (cm) in length from the surface of the chin, but curled upward. Resident #36 stated she likes for the chin hair to be shaved off, had not recently asked staff to do it, but they had done it in the past. She stated she couldn't recall when it was last done, but it was more than two (2) weeks ago. Resident #36 stated she received a daily bed bath and went to the shower about once a week. An observation and interview on 07/24/19 at 8:39 AM, revealed the resident with visible chin hair. Resident #36 stated the chin hair was bothersome to her and she preferred it be shaved and had not ever refused to be shaved. The resident stated staff had not asked her if she wanted it shaved. An interview and observation of Resident #36, on 07/25/19 at 9:18 AM, with CNA #1, revealed the resident had curled chin hair. With Resident #36's permission, CNA #1 extended the chin hairs from the curled position to straight and CNA #1 estimated the hairs to be approximately one (1) inch long. CNA #1 stated the hair appeared to not have been shaved for at least two (2) weeks. CNA #1 stated that she had been regularly assigned to Resident #36 and had not noticed the chin hair. CNA #1 stated that she really hadn't paid attention. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene, which would include shaving as needed. Resident #59 A review of Resident #59's comprehensive care plan revealed the resident had an ADL care plan with an onset date of 05/01/08, a goal and target date of 08/25/19, with an approach to dress,	F 656	problems noted will be reported to the Quality Assurance Committee at least quarterly to make recommendation/changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 11 bathe, and groom daily, keep clean and neat. CNA was listed as staff responsible for completion of the approach. A review of Resident #59's current care plan revealed an ADL care plan with an onset date of 05/01/08, with an intervention to provide oral care every shift and observe for mouth pain/problems during oral care. There was no care plan addressing dental exams. An observation on 07/23/19 at 9:58 AM, revealed Resident #59 in her room lying in bed. The resident was not verbally responsive. The resident had a patch of hair visible on right side of chin approximately one (1) cm from the surface of her chin, curled. An observation on 07/24/19 at 10:09 AM, of Resident #59 in the day room area near the nurse's station, revealed Resident #59 seated in a Geri-chair. The resident's chin hair glistened as it caught the sunlight. A review of Resident #59's most recent quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/28/19, revealed Resident #59 is totally dependent on staff to take care of personal hygiene needs. An interview and observation on 07/25/19 at 09:23 AM, with CNA #1, revealed Resident #59 had curled chin hair. In order to measure the hair, CNA #1 extended the chin hairs from the curled position to straight and estimated the hairs to be approximately one (1) inch long. CNA #1 stated it had probably been at least a couple of weeks since the hair had been shaved, but she was unsure. CNA #1 stated that she had been	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 12 regularly assigned to Resident #59 and really hadn't paid attention. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene, which would include shaving. An interview on 07/25/19 at 2:52 PM, with the Administrator and the Director of Nursing (DON) revealed it was expected that staff complete all tasks assigned to them. The DON stated hygiene tasks should be completed during daily baths and as needed and she expected staff to do their job everyday. The DON stated it was the responsibility of nursing staff to complete hygiene tasks and it was expected the tasks be completed per resident preferences. The DON stated grooming included shaving. The DON stated if residents were not shaved if it were their preference to be, the care plan was not followed. An interview on 07/25/19 at 03:50 PM, with Resident #59's brother, (FM #2), revealed before Resident #59 got sick she was a person who prided herself on her appearance. The brother stated the resident would not want to have facial hair present and would want the hair to be shaved or plucked out. An observation on 07/23/19 at 09:58 AM, revealed Resident #59 lying in bed in her room. The resident was not verbal and had dry, cracked skin on her lips, several teeth were missing, with her visible bottom teeth appearing jagged with dark areas of decay present. A review of Resident #59's record revealed no indication of a dental exam in the past year. A review of Resident #59's physician's orders for	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 13 July 2019 revealed an order with a start date of 04/17/17, which noted, "May see dentist prn (as needed)". On 7/25/19 at 04:51 PM, interview with DON revealed the resident had been seen by a dentist, taken by her son, but she couldn't remember when. The DON asked LPN #2 to call the resident's son to see when the resident went to the dentist. LPN #2 called the resident's son and he told her it was in 2016, and it was recommended some teeth be pulled and recommended the resident be sedated to do so, but the attending physician wouldn't approve the resident having the procedure due to her condition at the time, it was unsafe to sedate her. The DON stated the facility used to have a dentist who came in to the facility to examine teeth, but did not currently have anyone. The DON stated she didn't know if Resident #59 had a dental exam since 2016. Review of the archived medical record revealed Resident #59's dental visits dated 11/15/16 and 03/08/17. The 11/15/16 visit indicated the resident did not have a dental exam due to the resident refusing and being combative. The 03/08/17 visit indicated the resident was seen due to bleeding gums and had gingivitis. Plan was to re-evaluate wear, gingivitis, bleeding gums, and plaque during the next scheduled visit. The facility was unable to provide evidence that any visit had been scheduled since 2017. A review of Resident #59's most recent comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/18, revealed Resident #59 was assessed to have cavity or broken natural teeth, had a decreased	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 14 ability to understand others or perform tasks, had poor dental health, obvious or likely cavities noted, and was dependent on staff for oral care. During an interview on 07/25/19 at 4:00 PM, the DON stated there was a care plan to provide oral care, but the care plan did not address dental visits or exams. The DON stated the care plan should be further developed to include regular dental exams for the resident to meet her needs. Resident #71 A review of Resident #71's comprehensive care plan revealed an ADL care plan with a problem onset date of 05/31/16, of "Requires staff assistance for ADL's related to paraplegia/impaired mobility, contracted legs". Goals included "Will be neat, clean, dressed, and groomed appropriately" with an approach to be completed by the CNA of "Bathe, dress, and groom". The care plan did not specifically address nails or nailcare. On 07/24/19 at 3:25 PM, Resident # 71 was observed in bed lying on the left side. The Resident's fingernails appeared approximately 0.75 cm from the nail bed and had build up of brown and reddish brown substances under the nails. Resident #71 stated the CNA told the nurse that his nails needed to be cut but the nurse came in and said she didn't think they needed to be cut. Resident #71 stated the substance was food built up. The resident stated he wasn't sure how long it had been since they had been cleaned, but buildup was thick and hard. On 07/25/19 at 9:13 AM, interview with Resident #71's sister revealed she often finds her brother's	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 15 fingernails to be dirty and when she is here she usually tries to clean them. She stated the build up under the nails is so thick now he is complaining they hurt when she tried to clean them this morning. She stated the right hand is more of an issue than the left, because he eats with that hand. The resident stated because his nails are long, the food gets caught under them. The resident's fingernails were observed to have dirt under all nails. The resident stated a nurse came to look at the nails and said they didn't need cutting, so he just went along with it. He stated if they were shorter, they wouldn't pick up as much food under them. Resident #71 stated the nails were sore. An interview on 07/25/19 at 9:32 AM, with CNA #2, revealed she was regularly assigned to Resident #71. CNA #2 stated she had attempted to clean the resident's fingernails this morning but the resident complained they hurt, so she stopped. CNA #2 stated she reported it to the nurse and had told the nurse the resident wanted his nails trimmed. CNA #2 declined to answer if she believed the resident's nails should be trimmed but stated the resident liked to eat finger foods that tended to get under his fingernails. CNA #2 stated she did think if the resident's nails were shorter, they would stay cleaner and be easier to clean. An interview on 07/25/19 at 2:52 PM, with the Administrator and the Director of Nursing (DON), revealed it was expected that staff complete all tasks assigned to them. The DON stated grooming included cleaning nails. The DON stated if residents had dirty or long nails, the care plan was not followed. Resident #31	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 16 Record review of Resident #31's current comprehensive care plan revealed no care plan was developed for the change in medical condition which involved two (2) hospital transfers for vomiting blood and new medication orders for nausea and vomiting. On 07/24/19 at 09:46 AM, an interview with Resident #31 revealed she had a recent hospital stay. On 7/24/19 at 4:01 PM, an interview with RN #1 confirmed there was no care plan developed for Resident #31 for the problem which resulted in hospital transfers and stays. RN # 1 confirmed Resident #31 has had episodes of vomiting blood and blood clots and should be care planned with interventions. RN #1 confirmed hand written orders were documented in the chart for two (2) transfers to the hospital for vomiting of blood. RN #1 revealed she is not sure if she every got a copy of the new orders or not. On 7/25/19 at 8:14 AM, an interview with the DON revealed the recent medical condition, where Resident #31 had episodes of vomiting blood clots and blood, should have been care planned, with interventions to address the change in condition. The DON revealed the nurses should update the paper care plans in the resident's charts with any changes or updates, then the Minimum Data Set (MDS) nurse updates the care plan in the computer. She stated that the MDS nurse should get the yellow copy of all new orders written and update the care plans from the new orders. Record review of the Physician's Orders for Resident #31 revealed orders written to transfer	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 656	Continued From page 17 to the hospital on 6/2/19, and 6/9/19, for vomiting of blood. Record review of the July monthly Physician's orders revealed an order written on 6/21/19, for Promethazine 25 milligram (mg) for nausea and vomiting. There was no care plan developed for the new orders and/or condition.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 657	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to revise the care plan related to an intervention to help prevent injury (use of padding for a bed rail) for one (1) of 19 care plans reviewed (Resident #88). Findings include: A review of the facility's "Care Plans - Comprehensive Person-Centered" policy, with a revision date of December 2016, revealed the comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative were to develop and implement a comprehensive, person-centered care plan for each resident. The policy further included the care plan was designed to incorporate identified problem areas and risk factors associated with identified problems and should be revised as information about the resident and resident condition changes. A review of Resident #88's Comprehensive Care Plan revealed a care plan with a problem onset date of 07/03/19, addressing the fracture of her left radius. The approaches were not revised to include using padding on the side rails. An observation on 07/24/19 at 08:30 AM, revealed Resident #88's bed had no padding on the side rails.	F 657	A. The Wound Care Nurse placed the padded side rails on the left hand side for Resident #88, then updated care plan for preventive measures on 07/25/19. B. Ninety-three (93) residents on the day of the survey had the potential to be affected by the deficient practice. Nine (9) residents currently have padded side rails. C. The Assessment Nurses will attend an inservice on 8/20/19 by the Director of Nursing on revising care plans relating to interventions to help prevent injuries. D. The Quality Assurance Nurse shall monitor reports of all injuries at least monthly beginning 08/23/19 for three (3) months and review each resident's care plan to ensure it has been revised with interventions to help prevent the injury from reoccurring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 657	Continued From page 19 A review of a facility reported incident dated 07/09/19, revealed Resident #88 sustained an injury of a subtle fracture of the distal radius of her left hand. The facility's investigation concluded it was unknown exactly how the injury occurred, but it was possibly during care, due to the resident's history of kicking, hitting and spitting. The resident also had diagnoses including Parkinson's Disease and degenerative interphalangeal joints. The report documented the care plan was going to be revised and there would be padding put on the side rail of the bed. An observation of Resident #88, and an interview on 07/23/19 at 3:42 PM, with Resident #88's daughter, (FM #3), revealed FM #3 was generally pleased with the resident's care. FM #3 stated her sister (FM #4) was notified of an injury to Resident #88's wrist on 07/02/19, and an X-ray was done on 07/03/19, that revealed a fracture. FM #3 stated the facility investigated the incident and she and FM #4 met with the facility Administrator, Director or Nursing (DON), and a nurse from the hospice care provider on July 9, 2019. FM #3 stated they were told by the facility that after completing their investigation, they were unsure what happened, but suspected she hit her wrist on something. They determined in the meeting that, as precaution to prevent any further injury, they would pad the side rail. FM #3 stated the side rail had not been padded yet, and it was now 07/23/19. There were 1/2 side rails observed on the resident's bed, with no padding, and Resident #88 was periodically using side rails to move around in the bed. Resident #88 had a splint on her left hand. The bed was positioned against the wall with approximately four (4) inches of space between the wall and bed rail.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 657	Continued From page 20 An interview on 07/24/19 at 05:00 PM, with the DON, revealed she was unable to determine the exact cause of Resident #88's injury. The DON stated she couldn't recall how or when the facility decided to put padding on the side rails, but did add padding to the rail today. The DON stated she attempted to pad the rails with sheepskin padding yesterday, but it wasn't adequate and could not be secured to the rail. The DON stated the padding should have been added sooner, and the care plan revised, as an intervention to prevent further injury. An interview with the DON and the Administrator on 07/25/19 at 3:03 PM, revealed there had been a meeting with Resident #88's family on 07/09/19, and discussed the injury. They did recall the discussion of placing padding on the side rails, but were not sure it was during the meeting with the family. They confirmed there were no minutes of the meeting. The DON confirmed the care plan did not include use of padding for bed rails and should have been revised to include use of padding sooner.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, resident interview, record review, and facility document review, the facility failed to provide nail care for Resident #25, and #71, and shave facial hair for Resident #36 and #59, for	F 677	A. Residents #25 and #71 were shaved on 07/25/19 by their assigned Certified Nursing Assistant. Residents #36 and #59 were provided nail care on 07/25/19 by their assigned Certified Nursing	8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 21 four (4) of 19 sampled residents. Findings include: A review of an untitled document provided by the facility on 07/25/19, revealed it was the protocol of the facility to have personal care, hygiene, and grooming needs met for all residents to include caring for fingernails and shaving. Resident #36 An observation and interview on 07/23/19 at 10:15 AM, revealed Resident #36 in her room lying in bed watching television. The resident appeared clean but had visible patches of chin hair curled up that extended approximately one (1) centimeter (cm) from the surface of her face. Resident #36 stated she liked for the chin hair to be shaved off. She stated the staff had shaved the chin hair in the past. She stated she could not recall when it was last done, but guessed it was more than two (2) weeks ago. An observation on 07/23/19 at 4:16 PM, revealed Resident #36 in her room in bed with chin hair present. Resident's eyes were closed and she was breathing deeply. An observation and interview on 07/24/19 at 08:39 AM, revealed Resident #36 sitting up in bed in her room. Resident #36 stated the chin hair was bothersome to her and she preferred for it to be shaved. Resident #36 stated she had never refused it to be shaved and staff had never asked her if she wanted it shaved. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/19, revealed resident had a Brief	F 677	Assistant. B. Ninety-three (93) residents on the day of survey had the potential to be affected by the deficient practice. C. Nursing staff will be inserviced by the Director of Nurses on 08/23/19 to observe any nail care needs or facial hair removal on bath days and as needed. Nail care will be provided by the Certified Nursing Assistants except for diabetics, whose nail care will be provided by the Licensed Practical Nurses. Shaving of facial hair will be provided by the Certified Nursing Assistants. D. The Registered Nurse Supervisor will do weekly checks beginning 08/08/19 for nail care and facial hair for three (3) months. Any problems noted will be reported to the Quality Assurance Committee for recommendations/changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 22 Interview of Mental Status (BIMS) of 12, indicating she had moderate cognitive impairment, and needed extensive assistance with one (1) person physically assisting her with personal hygiene. An interview on 07/24/19 at 03:43 PM, with Licensed Practical Nurse (LPN) #2, revealed all residents in the facility received a bed bath everyday if they didn't have a shower/whirlpool bath. LPN #2 stated during baths all personal hygiene needs should be completed including nail care, grooming, and shaving. LPN #2 stated the Certified Nursing Assistants (CNAs) should record tasks performed on the Activities of Daily Living (ADL) sheet electronically. LPN #2 stated the CNA Coordinator was responsible for checking to make sure the tasks were completed. An interview and observation on 07/25/19 at 09:18 AM, with CNA #1, of Resident #36, revealed the resident had curled chin hair. With Resident #36's permission, CNA #1 extended the chin hairs from the curled position to straight. The chin hair was estimated to be approximately one (1) inch long. CNA #1 stated the hair appeared to not have been shaved for at least two (2) weeks. CNA #1 stated that she had been regularly assigned to Resident #36, but had not really paid attention to the resident's chin hair. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene which would include shaving. CNA #1 stated she didn't remember doing it, but if she had she would have recorded it on the kiosk (electronic documentation instrument). CNA #1 demonstrated on the kiosk how the tasks performed were recorded, and the tasks did include an area to mark for shaving. There was	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 23 no shaving recorded for the months of June 2019, or July 2019. A review of a print out, provided by the facility, titled "Nail Care Report", revealed a column under Personal Hygiene with a task of "shaving/hair removal". The column did not have any mark to indicate completion of shaving/hair removal from 06/01/19 through 07/24/19 for Resident #36. Resident #59 An observation on 07/23/19 at 09:58 AM, revealed Resident #59 in her room lying in bed. The resident was not verbally responsive. The resident had a patch of curled hair visible on the right side of her chin, approximately one (1) cm from the surface of her chin. A review of Resident #59's most recent quarterly MDS, with an ARD of 5/28/19, revealed Resident #59 was totally dependent on staff to take care of personal hygiene needs. An observation on 07/24/19 at 10:09 AM, revealed Resident #59 sitting in the dayroom near the nurse's station in a Ger-chair. The resident's chin hair glistened in the sunlight as it shone through the window, visible from the nurse's station, approximately 20 feet away. An interview and observation on 07/25/19 at 09:23 AM, with CNA #1, of Resident #59, revealed the resident had curled chin hair. In order to measure the hair, CNA #1 extended the chin hairs from the curled position to straight and estimated the hairs to be approximately one (1) inch long. CNA #1 stated it had probably been at least a couple of weeks since the hair had been shaved, but she was unsure. CNA #1 stated that	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 24 she had been regularly assigned to Resident #59 and had not noticed the chin hair. CNA #1 stated that she really hadn't paid attention. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene, which would include shaving. CNA #1 stated she didn't remember doing it, but if she had, she would have recorded it on the kiosk. An interview on 07/25/19 at 03:50 PM, with Resident #59's brother (FM #2), revealed before Resident #59 got sick she was a person who prided herself on her appearance. FM #2 stated the resident would not want to have facial hair present and would want it to be shaved or plucked out. A review of a print out, provided by the facility, titled " Nail Care Report", revealed a column under Personal Hygiene with a task of "shaving/hair removal". The column did not have any mark to indicate completion of shaving/hair removal from 06/01/19 through 07/24/19. Resident #71 An observation and interview on 07/24/19 at 03:25 PM, revealed Resident #71 lying on his left side in bed. The resident's fingernails appeared approximately 0.75 cm from the nail bed, with build up of brown and reddish brown substance under the nails of both hands. Resident #71 stated the CNA told the nurse that his nails needed to be cut this morning, but the nurse came in and said she didn't think they needed to be cut. Resident #71 stated the substance was food built up. The resident stated he wasn't sure how long it had been since they had been cleaned, but buildup was thick and hard.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 25 A review of Resident #71's Quarterly MDS, with an ARD of 06/07/19, revealed the resident had a BIMS score of 9, which indicated the resident had moderate cognitive impairment and the resident was totally dependent on staff to complete personal hygiene needs. The resident required the assistance of 1 (one) staff person to assist with personal hygiene. An observation and interview on 07/25/19 at 09:13 AM, with the resident's sister (FM #1), and Resident #71, revealed the resident's sister often found the resident's fingernails to be dirty when she visited. FM #1 stated she usually tried to clean the nails when she was here. FM #1 stated the build up under the nails was so thick now the resident complained they hurt when she attempted to clean them. FM #1 stated the right hand was more of an issue than the left, because the resident ate with that hand. Resident #71 stated food gets caught under his nails, because his nails are long. Resident #71's nails had dirt under all nails. The resident stated a nurse came to look at the nails and said they didn't need cutting, so he just went along with it. Resident #71 stated if the nails were shorter they wouldn't pick up as much food under them. Resident #71 stated the nails were sore. An interview on 07/25/19 at 09:32 AM, with CNA #2, revealed she was regularly assigned to Resident #71. CNA #2 stated she had attempted to clean the resident's fingernails this morning, but the resident complained they hurt and so she stopped. CNA #2 stated she reported to the nurse and had told the nurse the resident wanted his nails trimmed. CNA #2 declined to answer if she believed the resident's nails should be trimmed, but stated the resident liked to eat finger	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 26 foods that tended to get under his fingernails. CNA #2 stated she did think if the resident's nails were shorter, they would stay cleaner and be easier to clean. An interview with the CNA Supervisor (LPN #3) on 07/25/19 at 9:51 AM, revealed she expected CNAs to shave hair, clean nails, and assist with all hygiene needs during the resident's daily bath. LPN #3 stated CNAs were expected to shave any facial hair per the resident's preference or the preference of the resident representative if the resident could not speak for themselves. LPN #3 stated she did periodic spot checks to make sure hygiene tasks were being completed, but did not keep documentation of this. LPN #3 stated that regarding nail care, CNAs were expected to assist the residents in washing hands prior to meals and after meals, which included checking nails, and cleaning as needed, after meals and/or as they check people throughout the day. LPN #3 stated any nursing staff could complete hygiene tasks. LPN #3 stated she had not noticed chin hair on Resident #36 or Resident #59 and had not recently noticed residents having dirty or untrimmed nails. An interview on 07/25/19 at 2:52 PM, with the Administrator and the Director of Nursing (DON), revealed it was expected that staff complete all tasks assigned to them. The DON stated hygiene tasks should be completed during daily baths and as needed and she expected staff to do their job everyday. The DON stated it was the responsibility of nursing staff to complete hygiene tasks and it was expected the tasks be completed per resident preferences. Resident #25 During an interview and observation on /24/19 at	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 27 12:00 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #25 had long, rough, and dirty fingernails. She confirmed Resident #25's right hand index and middle finger had a dark brown substance under the nail. On 07/24/19 at 12:05 PM, an interview with Resident # 25 revealed she always does her own finger nails, the staff does not usually do them. Resident #25 revealed she tried to clean them when she notices they are dirty. On 07/24/19 at 12:10 PM, an interview with the LPN #1 confirmed Resident #25's fingernails were dirty, long, and rough. LPN #1 revealed that there is no excuse for not keeping her nails clean and smooth. LPN #1 revealed the resident just finished eating and her dirty fingernails could be a source of spreading an infection if not clean for meal times. LPN #1 revealed the Certified Nursing Assistants (CNA) clean and trim non-diabetic fingernails one (1) time a week and they should be cleaned on bath days. LPN #1 confirmed they look like they have not been cleaned or trimmed in a while. On 07/25/19 at 9:00 AM, an interview with the Director of Nursing (DON) revealed she was made aware of Resident #25's fingernails and confirmed they were long and dirty. The DON confirmed that it was everyone's responsibility to clean and trim resident's nails when they are dirty or long. Record review of Resident #25's nail care report revealed from 6/1/19 to 7/25/19, nail care (cleaning/trimming) was provided only one (1) time on 6/20/19.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 677	Continued From page 28 Record review of the MDS for Significant Change, dated 4/18/19, revealed Resident #25 required extensive assistance of one (1) staff for personal hygiene.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and family interview, the facility failed to implement an intervention (pad side rail) that was discussed with family, to help prevent further injury after a resident had received a prior injury to her hand for one (1) of four (4) residents reviewed for accidents/hazards, Resident #88. Findings include: A review of a facility reported incident dated 07/09/19, revealed the facility reported an injury of unknown source in which no abuse was suspected. Resident #88 sustained an injury of a subtle fracture of the distal radius of her left hand. The facility's investigation concluded it was unknown exactly how the injury occurred, but it was possibly during care, due to the resident's history of kicking, hitting and spitting. The resident also had diagnoses including Parkinson's Disease and degenerative	F 689	A. Padded side rails were added to the left side of the bed for Resident #88 by the Wound Care Nurse on 07/25/19. B. Ninety-three (93) residents on the day of survey had the potential to be affected by the deficient practice. Nine (9) residents currently have padded side rails. C. Nursing staff will be inserviced by the Director of Nursing on 08/23/19 concerning providing interventions to prevent injuries to residents. D. The Quality Assurance Nurse will review incident reports since survey exit to we if any needed interventions were put in to place monthly for three (3) months beginning 08/23/19 and check to see if interventions were put in place to prevent the incident from reoccurring. Any problems noted will be reported to the Quality Assurance Committee for recommendations/changes.	8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 689	Continued From page 29 interphalangeal joints. The report documented the care plan was going to be updated and there would be padding put on the side rail of the bed. An observation of Resident #88 and an interview on 07/23/19 at 03:42 PM, with Resident #88's daughter (FM #3), revealed FM #3 was generally pleased with the resident's care, but they were concerned about a fracture that happened on or around 07/02/19. FM #3 stated her sister (FM #4) was notified of the injury on 07/02/19, and an X-ray was performed on 07/03/19, that revealed a fracture to Resident #88's wrist. FM #3 stated her mother had a bone screening a few years ago, which indicated her bones were like "Swiss cheese". FM #3 stated she and FM #4 met with the facility Administrator, Director of Nursing (DON), and a nurse from the hospice care provider regarding the injury on July 9, 2019. FM #3 stated the facility suspected the resident hit her wrist on something and determined in the meeting that, as precaution to prevent any further injury, they would pad the side rail. FM #3 stated the side rail had not been padded yet and it was now 07/23/19. Observation revealed there were 1/2 side rails up with no padding and Resident #88 periodically used the side rails to move around in bed. Resident #88 had a splint on her left hand. The bed was positioned against the wall with approximately four (4) inches of space between the wall and the bed rail. At 04:02 PM, the DON approached the doorway to Resident #88's room, during the surveyor interview with FM #3, with a sheepskin pad in her hands and stated she would return shortly to put it on the side rail. An observation on 07/24/19 at 08:30 AM revealed Resident #88's bed had no padding on the side rails.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 689	Continued From page 30 An interview on 07/24/19 at 5:00 PM, with the DON, revealed she was unable to determine the exact cause of Resident #88's injury. The DON stated she couldn't recall how or when the facility decided to put padding on side rails, but did add padding to the rail today. The DON stated she attempted to pad the rails with sheepskin padding yesterday, but it wasn't adequate and could not be secured to the rail. The DON stated the padding could have been added sooner as an intervention to prevent further injury. An interview with the DON and the Administrator on 07/25/19 at 3:03 PM, revealed there had been a meeting with Resident #88's family on 07/09/19, to discuss the resident's injury. They did recall the discussion of placing padding on the side rails, but they were not sure it was during the meeting with the family. They did not record any minutes of the meeting. They did agree the padding should have been placed and care planned.	F 689		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and	F 791		8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 791	Continued From page 31 (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility document review, the facility failed to ensure Resident #59 received routine dental care for one (1) of 19 sampled residents. Findings Include: A review of an untitled document provided by the facility on 07/25/19, revealed it was the protocol	F 791	A. A dental exam was performed on 08/08/19 for Resident #59. The dentist referred her to an oral surgeon. Her Responsible Party stated on 08/12/19 that her physician had stated in the past that she was not a candidate for surgery, and he did not want appointment pursued. Her attending physician stated to Director of Nursing on 08/20/19 that she is unable	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 791	Continued From page 32 of the facility that routine and emergency dental services were available to meet the residents' oral health needs according to the resident assessment and plan of care. An observation on 07/23/19 at 09:58 AM, revealed Resident #59 lying in bed in her room. The resident was not verbally responsive. Resident #59 had a continuous food pump and was making chewing motions with her mouth. The resident's lips were dry, she had several teeth missing and bottom teeth were jagged, some broken with dark decayed appearance. A review of Resident #59's record revealed no indication of dental exams in the past year. An interview on 07/24/19 at 04:51 PM, with the Director of Nursing (DON), revealed the resident had been seen by a dentist but she couldn't remember when. The DON stated she recalled the resident's son taking the resident to the dentist. The DON asked LPN #2 to call the resident's son to see when the resident went to the dentist. LPN #2 stated the son told her it was in 2016, and it was recommended some teeth be pulled and recommended the resident be sedated to do so, but the attending physician wouldn't approve the resident having the procedure due to her condition at the time; because it was unsafe to sedate her. The DON stated the facility formerly had a dentist who came to the facility to examine teeth, but did not currently have anyone. A review of Resident #59's current July 2019 physician orders revealed an order with a start date of 04/17/17, which noted, "May see dentist PRN (as needed)."	F 791	to withstand any surgery. B. Ninety-three (93) residents on the day of the survey had the potential to be affected by the deficient practice. One other resident has seen the dentist since survey. He was referred to an oral surgeon as well, and his appointment was made for 08/26/19. C. A local dentist has agreed to provide routine dental care to the residents of our facility effective 08/23/19. Minimum Data Set Assessment Nurses and Nursing Staff will be inserviced by the Director of Nursing on 08/23/19 on observing the residents' oral hygiene at least quarterly during their assessments and as needed. Social Services will monitor routine dental services for ten (10) different residents monthly for three (3) months beginning 08/23/19. Any problems noted will be reported to the Quality Assurance Committee at least quarterly for recommendations/changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 791	Continued From page 33 A review of Resident #59's most recent comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/18, revealed Resident #59 was assessed to have cavity or broken natural teeth, had a decreased ability to understand others or perform tasks, had poor dental health, obvious or likely cavities noted, and was dependent on staff for oral care. A review of Resident #59's care plan revealed an Activity of Daily Living (ADL) care plan, with an onset date of 05/01/08, with an intervention to provide oral care every shift and observe for mouth pain/problems during oral care. There was no care plan addressing dental exams. An interview with Certified Nursing Assistant (CNA) #1, on 07/25/19 at 09:18 AM, revealed it was difficult to provide oral care to the resident because she would clench her mouth shut most of the time and wouldn't let staff brush her teeth. CNA #1 stated there are times when there is a strong odor from the resident's mouth and she had told the nurses about the odor. An interview on 07/25/19 at 10:02 AM, with Licensed Practical Nurse (LPN) #1, revealed she was aware of Resident #59's oral issues. LPN #1 stated there were attempts to provide oral care every shift. LPN #1 stated she had noticed a strong odor on some days. LPN #1 stated the facility did not have an onsite dentist and resident's were usually sent out for dental care. As far as she was aware, and looking back over the past year in the appointment calendar, Resident #59 had not been seen by a dentist in at least a year. LPN #1 stated all residents have standing orders for seeing the dentist as needed.	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 791	Continued From page 34 The facility provided documentation from Resident #59's archived medical record of dental visits dated 11/15/16, and 03/08/17. The 11/15/16 visit indicated the resident did not have a dental exam due to the resident refusing and being combative. The 03/08/17 visit indicated the resident was seen due to bleeding gums and had gingivitis. Plan was to re-evaluate wear, gingivitis, bleeding gums, and plaque during next scheduled visit. The facility was unable to provide evidence that any visit had been scheduled since 2017. An interview on 07/25/19 at approximately 2:52 PM, with the facility Administrator and the DON, revealed there had not been any efforts to secure an in-house dentist since the former in-house dentist stopped visiting the facility in 2017. Residents were sent out for dental care. An interview on 07/25/19 at 03:50 PM, with Resident #59's brother, (FM #2), confirmed he took Resident #59 to the dentist in 2016, and the dentist said she would need to be sedated to have some teeth pulled but her doctor thought the benefit outweighed the risk. Mr. Harris stated no one at the facility had requested he take his sister to the dentist since then. An interview on 07/25/19 at 4:00 PM, with the DON, revealed there was a care plan to provide oral care, but the care plan did not address dental visits or exams. The DON stated the care plan should be revised to include regular dental exams for the resident to meet her needs.	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey and a complaint investigation of MS Complaint # 16017 at the facility from 07/23/19 through 07/25/19. During the annual survey, the SA determined the facility was not in compliance with Medicaid and Medicare Requirements of Participation. The SA cited deficiencies at F623, F625, F656, F657, F677, F689, and F791. The Complaint was found to be unsubstantiated with no deficiencies cited. The facility was licensed for 96 bed and had a census of 93 at the time of survey.	F 000		

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

Electronically Signed | 08/19/2019

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET/P. O. BOX 488** **CANTON, MS 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
K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/15/2019

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. BUILDING _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 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
E 000	Initial Comments EMERGENCY PREPAREDNESS Survey conducted on 07/25/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 08/15/2019

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 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.