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 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	**1421-A EAST PEACE STREET 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 five (5) Complaint Investigations (CIs), CI #16652, CI #16924, CI #17206, CI #17523, and CI #17854 from 07/26/2021 to 07/29/2021. The SA did not substantiate MS # 16652 no pressure sore precautions taken by facility, facility staffing, CI MS #16924 Resident/patient/client abuse, CI MS # 17206 Resident left wet for extended period of time due to short staff, facility staffing, CI MS # 17523 Injury of unknown origin and CI MS # 17854 Resident denied visitation, and no deficiencies were cited. The facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements for participation in Medicare and Medicaid. The facility was licensed for 95 beds with a census of 91.	F 000		

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