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 _____	08/31/2018

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 Survey Agency (SA) conducted an annural recertification survey at Madison County Nursing Home in Canton from 8/29/18 to 8/31/18. During the survey, the SA determined the facility wa in compliance with Medicare and Medicaid requirements for participation. At the time of the survey the census was 94, and the facility held a license for 95 beds.	F 000		

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

Electronically Signed | 09/18/2018

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 _____	**09/04/2018**

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 must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide a one half hour rating in accordance with NFPA 101 sections 8.3, 19.3.7.3, and 19.3.7.6. The deficient practice affected two (2) of six (6) smoke compartments and 32 of 94 residents on the day of the survey. Findings include: On 9/4/18 at 11:15 AM, observation revealed an unsealed, penetration above lay-in ceiling in the smoke barrier wall located on the 200 Hall of the	K 372	A. The penetration in the smoke barrier wall on the 200 hall was sealed with fire stop sealant by the Maintenance Supervisor on 9/4/18. B. 32 of 94 residents on the day of survey had the potential to be affected by the deficient practice. C. On 9/21/18 the Administrator inserviced the Maintenance Supervisor to inspect all smoke barriers at least monthly for penetrations and make any needed repairs immediately.	9/21/18

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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 _____	**09/04/2018**

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 372	Continued From page 1 facility. The finding was acknowledged by the Administrator and Maintenance Director verified this observation during the exit interview on 9/4/18.	K 372	D. The Maintenance Supervisor will inspect all smoke barriers at least monthly for four months and make any needed repairs immediately. The Quality Assurance Committee will evaluate the Maintenance Supervisor's assessments at least quarterly.	

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	255329	A. BUILDING _____ B. WING _____	09/04/2018

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E 000	Initial Comments Survey conducted on 9/4/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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