STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review and staff interviews, the facility failed to ensure staff followed the plan of care related to Enhanced Barrier Precautions (EBP) during high contact resident care for one (1) of three (3) residents reviewed for infection prevention practices. (Resident #2).Findings Include: Record review of the facility policy Following the Care Plan Policy date 1/2011 revealed, Policy: It is the policy of this facility to follow a written and approved care plan for each resident. All employees will be.required to follow the care plan. A record review of the Care Plan Report revealed Focus: Resident has pressure ulcer.Interventions/Tasks.Enhanced barrier precautions, follow facilities protocol.A record review of the admission Record for Resident #2 revealed she was admitted on [DATE] with diagnoses that included nondisplaced fracture of the medial condyle of the right femur.A record review of the Minimum Data Set (MDS) assessment with an Assessment Reference Date of 04/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact.A record review of the Order Summary Report with active orders as of 5/27/26 revealed an order dated 04/24/26 for treatment of a Stage IV sacral pressure injury with Negative Pressure Wound Therapy (NPWT) at 125 mmHg continuous pressure with dressing changes every Monday, Wednesday, and Friday and as needed. The record also revealed an order for Enhanced Barrier Precautions dated 05/26/26.During an observation on 05/26/26 at 2:35 PM, Resident #2 was observed receiving incontinent care. During the provision of care, Certified Nursing Assistant (CNA) #1 was observed providing hands on care without wearing a gown despite the resident being identified for Enhanced Barrier Precautions.During an interview on 05/26/26 at 2:45 PM, CNA #1 confirmed she did not wear a gown while providing incontinent care to Resident #2. CNA #1 stated she should have worn a gown to prevent the spread of infection and to comply with the resident's Enhanced Barrier Precautions. CNA #1 further stated residents requiring Enhanced Barrier Precautions are identified by a green dot displayed outside the resident's room.During an interview on 05/27/26 at 9:15 AM, the Director of Nursing (DON) stated staff are expected to follow Enhanced Barrier Precautions when caring for residents with chronic wounds or indwelling medical devices to prevent infection transmission. The DON further stated staff should perform appropriate hand hygiene and utilize required personal protective equipment during resident care.During an interview on 05/27/26 at 1:05 PM, the facility's care plan nurses stated Enhanced Barrier Precautions should have been followed during incontinent care for Resident #2 as directed in the resident's care plan. The care plan nurses stated failure to follow resident specific care plan interventions could increase the risk of infection transmission and compromise resident safety. They further stated the purpose of the care plan is to direct staff regarding the individualized care needs of each resident.During a follow up interview on 05/27/26 at 2:25 PM, the DON confirmed Resident #2's care plan was not followed when CNA #1 failed to wear a gown during incontinent care. The DON stated the resident's chronic Stage IV sacral wound required Enhanced Barrier Precautions and acknowledged that failure to follow those precautions could increase the risk of wound infection.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure physician ordered Negative Pressure Wound Therapy (NPWT) was monitored and maintained in working order for one (1) of three (3) residents reviewed for wound care. Resident #2.Findings Include: Record review of the facility policy Negative Pressure Wound Therapy (NPWT) dated 7/2025 revealed, .9. Monitoring throughout the use of NPWT shall include, but is not limited to, the following: a. Pain associated with the therapy. b. Device is functioning. c. Settings as prescribed. d. Troubleshooting of any alarms, in accordance with pump/product specifications. e. Response of the therapy, including wound characteristics and progress towards healing . A record review of the Order Summary Report with active orders as of 5/27/26 revealed an order dated 04/24/26 for treatment of a Stage IV sacral pressure injury with Negative Pressure Wound Therapy at 125 mmHg (millimeters of mercury) continuous pressure with dressing changes every Monday, Wednesday, and Friday and as needed. During an observation on 05/26/26 at 12:30 PM, Resident #2's wound vacuum machine was observed connected to the resident but not functioning. The screen was not illuminated, no sounds were emitted from the unit, and no drainage was observed moving through the tubing.During a follow up observation on 05/26/26 at 2:30 PM, while incontinent care was being provided, the wound vacuum remained connected to the resident and continued to be nonfunctional. Following completion of incontinent care, the wound vacuum dressing was observed to have lost its seal and become detached.During an interview on 05/26/26 at 2:45 PM, Certified Nurse Assistant (CNA) #1 stated she was unaware the wound vacuum was not functioning prior to providing care and indicated she would notify the wound care nurse. Resident #2 and her granddaughter stated the resident frequently remains incontinent for extended periods despite using the call light. They stated the resident has a chronic Stage IV sacral wound and urine often causes the wound vacuum dressing to lose its seal. They further stated staff do not routinely monitor the wound vacuum's function. They reported that on the day of observation, Resident #2 returned from physical therapy wet with urine, called for assistance multiple times, and no staff responded before incontinent care was eventually provided. They stated the wound vacuum was not functioning during therapy and remained nonfunctional afterward.During an interview on 05/27/26 at 9:05 AM, Licensed Practical Nurse (LPN) #1, the wound care nurse, stated staff had been instructed to notify her if a wound vacuum was not working and to apply a wet to dry dressing if the device became nonfunctional until she could assess the resident. She stated no staff member notified her at approximately 12:30 PM on 05/26/26 that the wound vacuum was not functioning. She further stated she first became aware of the issue at approximately 2:45 PM when notified by CNA #1 after incontinent care had been completed. At that time, she contacted the Nurse Practitioner (NP) who instructed her to apply a wet to dry dressing rather than reapply the wound vacuum.During an interview on 05/27/26 at 9:15 AM, the Director of Nursing (DON) stated the facility did not have routine checks of wound vacuum functionality in place, such as every two hours. The DON stated implementing such monitoring may be necessary to ensure devices are functioning properly. The DON further stated a malfunctioning wound vacuum and prolonged exposure to urine could contribute to wound deterioration and infection. The DON stated nursing assistants are responsible for checking incontinent residents at least every two hours and providing care as needed to prevent skin breakdown and wound deterioration.During an interview on 05/27/26 at 2:10 PM, the NP stated a wound vacuum remaining inoperable for periods of time could delay wound healing. The NP further stated prolonged exposure to urine could contribute to breakdown of the peri wound tissue and reduce the wound's ability to heal.A record review of the admission Record for Resident #2 revealed she was admitted on [DATE] with diagnoses that included nondisplaced fracture of the medial condyle of the right femur.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 04/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and facility policy review, the facility failed to implement and maintain an effective infection prevention and control program for one (1) of three (3) residents reviewed for infection control practices. (Resident #2)Findings Include: Record review of the facility policy Enhanced Barrier Precautions dated 10-23 revealed, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . Record review of the facility policy Hand Hygiene Policy dated 5-25 revealed, .6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. During an observation on 05/26/26 at 2:35 PM, Resident #2 was observed receiving incontinent care. Certified Nurse Assistant (CNA) #1 removed a brief that was visibly heavily soiled and saturated with urine to the extent urine was observed leaking from the sides of the brief. During the provision of care, CNA #1 removed her gloves and applied a new pair prior to performing perineal care. Following perineal care, CNA #1 again removed her gloves and applied a new pair before providing bowel incontinence care. During each glove change, CNA #1 failed to perform hand hygiene prior to applying clean gloves. CNA #1 was also observed providing incontinent care without wearing a gown despite Resident #2 being on Enhanced Barrier Precautions (EBP).During an interview on 05/26/26 at 2:45 PM, CNA #1 confirmed she failed to perform hand hygiene between glove changes. CNA #1 stated she should have performed hand hygiene between glove changes to prevent the spread of infection. CNA #1 further confirmed she failed to wear a gown during care and stated she should have worn a gown to comply with EBP and prevent infection transmission. CNA #1 stated residents requiring EBP are identified by a green indicator outside the resident's room.During an interview on 05/27/26 at 9:15 AM, the Director of Nursing (DON) stated staff are expected to follow EBP when caring for residents with chronic wounds or indwelling medical devices and are expected to perform hand hygiene between each glove change to prevent the spread of infection.During an observation on 05/27/26 at 10:37 AM, Licensed Practical Nurse (LPN) #1 was observed providing wound care to Resident #2's Stage IV sacral pressure injury. During the procedure, LPN #1 used gauze to cleanse stool from the lower portion of the wound area. After discarding the soiled gauze, LPN #1, while continuing to wear the same gloves contaminated with fecal material, obtained additional gauze and proceeded to cleanse the wound bed. LPN #1 then obtained another gauze and cleansed the skin surrounding the wound without changing gloves or performing hand hygiene.During an interview on 05/27/26 at 11:18 AM, LPN #1 confirmed she cleansed the wound bed after removing stool from the wound area while wearing the same gloves. LPN #1 stated this practice could contaminate the wound with bacteria from stool and potentially result in wound infection, sepsis, increased drainage, increased slough, increased exudate, delayed healing, or cessation of wound healing. LPN #1 further stated Resident #2 had recently completed a course of antibiotics for a positive wound culture within the previous 14 days.During an interview on 05/27/26 at 11:27 AM, the DON stated the nurse should have removed contaminated gloves and performed hand hygiene before proceeding with wound care. The DON stated failure to do so could contaminate the wound and increase the risk of infection. The DON further stated her expectation was that staff follow infection prevention practices during all resident care.During an interview on 05/27/26 at 11:30 AM, the Infection Preventionist (IP) stated CNA #1 should have performed hand hygiene between glove changes and worn a gown as required by EBP. The IP further stated LPN #1 should have removed contaminated gloves and performed hand hygiene after handling stool contaminated materials before cleansing the wound bed. The IP stated failure to follow these infection prevention practices increased the risk of contaminating the wound and exposing the resident to infection.A record review of the admission Record for Resident #2 revealed she was admitted on [DATE] with diagnoses that included nondisplaced fracture of the medial condyle of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right femur.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 04/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 was cognitively intact.A record review of the Order Summary Report with active orders as of 5/27/26 revealed an order dated 04/24/26 for treatment of a Stage IV sacral pressure injury with Negative Pressure Wound Therapy (NPWT) at 125 mmHg continuous pressure with dressing changes every Monday, Wednesday, and Friday and as needed. The record also revealed an order for Enhanced Barrier Precautions dated 05/26/26.