STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Madison CO NH		STREET ADDRESS, CITY, STATE, ZIP CODE 1421-A East Peace Street Canton, MS 39046	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to ensure the resident's right to be free from abuse for one (1) of (20) sampled residents. Resident # 53Findings include:Record review of facility policy; Abuse Policy and Procedure , revision date April 2021 revealed, Residents have the right to be free from abuse. Policy interpretation and implementation: The resident abuse, neglect and exploitation prevention program consist of facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse. by anyone including but not necessarily limited to: a. facility staff . Record review of the facility investigation dated 4/21/26 revealed on 4/17/26 CNA # 1, Certified Nurse Aide (CNA), reported to Licensed Practical Nurse (LPN) # 4, that Resident #1 had a bruised left eye. Review revealed CNA # 1 reported the injury may have occurred while pushing Resident #53 to the dining table due to the resident's short, stooped posture. Record review further revealed the CNA reported Resident #53 used a racial slur toward her and she verbally responded but denied striking the resident.During an interview on 04/27/2026 at 11:30 AM, with Resident #53 she was unable to recall the incident in question. During an interview on 04/28/2026 at 2:00 PM, LPN #4 stated Resident #53 reported being hit in the eye by CNA #1. LPN#4 stated CNA # 2 reported she heard a commotion but did not witness the incident. She stated that when CNA #2 observed the resident's injury and asked what happened, Resident #53 reported she struck CNA #1 and was struck back in the eye, while making a motion consistent with a slap. She stated the resident provided a similar account to her. LPN # 4 revealed she reported the incident and removed CNA #1 from the unit with instructions not to return. During an interview on 04/28/2026 at 2:45 PM, CNA #2 stated she heard a commotion and later observed bruising to Resident #53's left eye. She stated that when she asked what happened, Resident #53 reported she hit CNA #1 and was hit back in the eye, while making a motion consistent with a slap.During an interview on 04/29/2026 at 11:00 AM, the Social Services Director stated she interviewed Resident #53 to assess psychosocial status following the incident. She reported the resident voiced no complaints and stated she felt safe. She stated the resident did not recall the incident, which she attributed to advanced dementia. She stated all residents assigned to the staff member involved were interviewed to assess any concerns related to abuse, neglect, or exploitation. She reported no additional allegations or concerns were identified. She stated she will continue to monitor Resident #53 for any changes in mood, behavior, or psychosocial well-being and will follow up as needed.During an interview on 04/29/2026 11:15 AM, the Director of Nurses (DON) revealed that following the investigation, it was determined that CNA # 1 struck Resident # 53 in the eye. She stated the staff member was removed from duty during the investigation and was subsequently terminated once the allegation was substantiated. The Administrator stated Resident # 53 was assessed by nursing the following day. On 04/21/2026, an emergency Quality Assurance and Performance Improvement meeting was conducted upon determination that abuse occurred. She stated Social Services interviewed the resident to assess psychosocial status. The resident voiced no additional complaints and did not recall the incident, which was attributed to advanced dementia. She further revealed that all residents assigned to CNA (continued on next page)

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: 255329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Madison CO NH		STREET ADDRESS, CITY, STATE, ZIP CODE 1421-A East Peace Street Canton, MS 39046	

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 0600 Level of Harm - Actual harm Residents Affected - Few	#1 were interviewed by Social Services, and no additional concerns were identified. The Resident Representative was notified by the Administrator and Director of Nursing regarding the investigation findings and cause of the injury. The Administrator stated a report was filed with the county police department. Written reports were submitted to the State Agency and the Attorney General's Office. She reported all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using Centers for Medicaid and Medicaid Services (CMS) Hand in Hand Module 5, as well as crisis intervention and de-escalation tools. She stated a memo was posted at the time clock directing staff to complete training at the start of their shift, and designated staff monitored compliance. All staff completed the required training by 04/22/2026.During an interview on 04/29/2026 at 11:38 AM, the Licensed Nursing Home Administrator (LNHA) stated that following the facility investigation, it was determined that CNA # 1 struck Resident #53 in the eye. He stated the staff member was immediately removed from duty during the investigation and was terminated upon confirmation of the allegation. He stated it was his decision to make the final determination to terminate CNA #1 even though it was not witnessed. He stated the resident was assessed by nursing the following day. He reported that on 04/21/2026, once the allegation was substantiated, the facility conducted an emergency Quality Assurance and Performance Improvement meeting. He stated Social Services interviewed the resident to assess psychosocial status. He reported the resident voiced no additional concerns and did not recall the incident, which he attributed to advanced dementia. He further stated all residents assigned to CNA #1 were interviewed by Social Services, and no additional concerns were identified. He confirmed the Resident Representative was notified by the Administrator and Director of Nursing regarding the findings of the investigation. He stated a report was filed with the county police department and written reports were submitted to the State Agency and the Attorney General's Office. He stated all staff received in service education on abuse, neglect, and exploitation, resident rights, recognizing and addressing burnout, and abuse prevention using CMS Hand in Hand Module 5, as well as crisis intervention and de-escalation techniques. He reported a memo was posted at the time clock directing staff to complete the training at the beginning of their shift, and staff compliance was monitored. He confirmed all staff completed the required training by 04/22/2026.Record review of the Face Sheet revealed Resident # 53 was admitted [DATE] to the Memory Care Unit with diagnoses including Alzheimer's disease, cognitive communication deficit, and unspecified dementia with behavioral disturbance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment.Record review of the Social Services progress note dated 4/21/26 at 12:31 PM, revealed Social Services and the Assistant Administrator followed up with Resident #53 upon her return from a supervised joy ride and after lunch to assess emotional and psychosocial status related to the alleged abuse incident. Documentation revealed when asked how she was doing and if everything was going okay, Resident #53 stated, It's good. When asked if she felt safe, the resident responded, Yes. Record review revealed the resident was documented to be in a good mood, voiced no concerns, and expressed no issues at the time of the follow up.Record review of the facility's abuse investigation concluded Resident #53 did not sustain the injury by accidentally striking the dining table and the facility determined that CNA # 1 struck Resident #53 in the eye. CNA # 1 was suspended pending investigation and subsequently terminated. The facility reported the allegation to the State Agency, the Attorney General's Office, and local law enforcement. The facility conducted an emergency Quality Assurance Performance Improvement (QAPI) meeting, notified the Resident Representative, interviewed additional residents assigned to CNA #1 and educated staff regarding abuse prevention, resident rights, recognizing burnout, and preventing abuse.Record review of the progress note dated 4/17/26 at 1:39 AM revealed acute follow up assessment related to left orbital ecchymosis from an injury identified on the prior shift. Documentation revealed a dark red circular bruise to the left eye region, dark purple bruising along the lateral bridge of the nose extending to the (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison CO NH	1421-A East Peace Street Canton, MS 39046

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 0600 Level of Harm - Actual harm Residents Affected - Few	superior left cheek, tenderness on palpation, minimal edema, and complaint of pain with the resident stating, It's sore. The residents' pupils were equal, round, and reactive to light and accommodation. Documentation noted due to advanced Alzheimer's disease, the resident was unable to reliably express symptoms such as blurred vision, double vision, dizziness, or headache, however nursing documented no apparent visual disturbance at that time. Interventions included staff assistance with transfers and toileting for safety, head of bed elevated to 45 degrees to reduce bruising, application of cold compresses to the eye area twice for ten minutes to reduce edema, and continued monitoring. Documentation revealed no acute distress, respirations even and unlabored, skin warm and dry, and resident resting quietly in bed. Vital signs were documented as temperature 97.5, pulse 79, respirations 16, and blood pressure 121/67. Further documentation revealed continued treatment and monitoring were implemented.