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 07/10/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44804

Based on observation, staff interview and facility policy review the facility failed to ensure a resident's dignity as evidenced by allowing the resident to sit in a public area with a private body part exposed for one (1) of 21 residents sampled. Resident #85

Findings include:

Review of the facility policy titled, Dignity with no revision date revealed under, Policy Interpretation and Implementation .#11. Staff promote, maintain and protect resident privacy, including bodily privacy .

An observation on 7/8/24 at 12:10 PM revealed Resident #85 sitting in a reclined wheelchair across from the centralized nurse's station wearing a tank top that had fell from her left shoulder exposing her breast. At this time there were approximately 10 other residents sitting in the area of the nurse's station and day room with staff and visitors walking past the resident.

An interview and observation on 7/8/24 at 12:15 PM with Licensed Practical Nurse (LPN) #1 revealed she is Resident #85's nurse and confirmed that the resident needed to be covered. She stated they were having trouble keeping the resident covered today. This observation revealed LPN #1 pulled the residents tank top strap up and began tucking a fleece blanket around the residents' shoulders then stated, I should've gone and got her something else to wear.

An interview and observation on 7/9/24 at 10:30 AM, with Certified Nurse Assistant (CNA) #2 revealed that Resident #85's closet had approximately 4 shirts with sleeves, two long sleeve gowns, 4 pairs of pants and a robe. She stated the CNA's dress the resident and the resident should always have clothes that fit her and do not expose her breast for the resident's dignity.

An interview on 7/9/24 at 11:00 AM, with LPN #1 confirmed that Resident #85 should have had better clothes on yesterday that did not expose her for the resident's dignity.

An interview on 7/9/24 at 1:30 PM, with the Director of Nurses (DON) confirmed that her expectation is that residents should be dressed in a manner that would keep them from exposing private body parts. She stated that Resident #85 having a breast exposed due to an ill-fitting tank top while sitting in the area near the nurses' desk would have been a dignity issue for the resident.

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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 07/10/2024
NAME OF PROVIDER OR SUPPLIER Madison CO NH		STREET ADDRESS, CITY, STATE, ZIP CODE 1421-A East Peace Street Canton, MS 39046	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #85's Face Sheet revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Senile Degeneration of Brain.

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(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** 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive person-centered care plan for a resident requiring grooming and personal hygiene and failed to develop a care plan for splint/mobility devices for three (3) of 21 care plans reviewed. Resident #20, Resident #44 and Resident #68 Findings Include: Review of the facility policy titled, Care Plans-Comprehensive with no revision date revealed under the Policy Statement .A comprehensive 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. Resident #20 Review of Resident #20's Care Plan revealed, ADLS (activities of daily living): Requires assistance with ADLS related to impaired functional ability/right sided hemiplegia, and cognitive impairment. Also revealed under, Approaches: . Hygiene and grooming daily . shave daily if facial hair is present . On 7/8/2024 at 11:44 AM, an observation revealed, Resident #20 lying in bed, non-communicative with grayish-black facial hair observed above the upper lip, under the lower lip, and to her chin, measuring approximately 1/4 (one-fourth) inch in length. The resident was wearing a hospital gown and had a tan colored liquid substance spread across the chest area of the gown and two (2) small, cubed pieces of carrot. An observation and interview with Registered Nurse (RN) #1 on 7/9/2024 at 10:15 AM, confirmed Resident #20's facial hair and acknowledged that when a resident had soiled clothing, it should be changed immediately. An interview with the Director of Nursing (DON) on 7/10/2024 at 8:25 AM, confirmed the ADL care plan was not followed and revealed the importance of following the plan of care was to provide the necessary care for Resident #20. Record review of the Face Sheet revealed the facility admitted Resident #20 on 6/29/2023 with medical diagnoses which included Hemiplegia following Nontraumatic Intracerebral Hemorrhage affecting right dominant side. 44804 Resident #44 (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 07/10/2024
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(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	Record review of Resident #44's care plans revealed the resident has a care plan regarding needing assistance with Activities of Daily Living (ADL) related to muscle weakness, occasional incontinence and cognitive impairment with interventions that include assist with grooming and spoon-feed all meals (CNA). On 07/08/24 at 2:06 PM, an observation revealed Resident #44 sitting in the day room dressed in personal clothes, with a sliced piece of carrot, approximately six (6) pieces of rice and a nickel size amount of a brown substance on her shirt around her chest area. On 7/9/24 at 1:20 PM, during an interview with the DON, she stated Resident #44 has to be fed by the staff and that she normally wears a bib, but she should be checked before leaving the dining room and cleaned to make sure food is not left on the resident. She revealed it was her expectation that this would be done for all residents. Record review of Resident #44's Face Sheet revealed the resident was admitted to the facility on [DATE]. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/24 revealed in Section GG that the resident was dependent on staff for eating. Resident #68 Review of a written physician's order for Resident #68 provided by the facility dated 2/10/22 revealed, resident to wear (L) left resting hand splint time four (4) hours per day with staff monitoring skin for irritation to decrease risk of worsening joint deformity with no discontinue date. Review of the Electronic Care Guide (ECARE) Care Plan for Resident #68 revealed no resting left-hand splint intervention listed. Review of the Comprehensive Care Plans for Resident #68 revealed no resting left-hand splint listed on any of the care plans. On 7/9/24 at 10:40 AM, during an interview with Restorative Nurse, she revealed after review of Resident #68's care plans and the ECARE guide for the Certified Nurse Assistants (CNAs), she confirmed she was unable to find the splinting device for the left hand listed on any of the care plans. Interview with the Minimum Data Set (MDS) Coordinator on 7/09/24 at 12:59 PM, she revealed the purpose of the comprehensive care plan is to direct resident specific care needs to staff. She then confirmed, if a resident had an order for a splinting device, the device should be a care-planned to reflect the resident's specific need. She confirmed, after review of Resident #68's care plans, they were not revised to reflect the left-hand resting splint. Interview with the Director of Nursing (DON) on 7/09/24 at 1:32 PM, she revealed the physician's order for the resting left-hand splint was never added to the ECARE care guide for the resident when she was discharged from Occupational Therapy (OT). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nursing Assistant (CNA) #3 on 07/09/24 at 2:02 PM, she revealed if a resident has a splint or other device ordered, it would trigger the CNA ECARE guide. She stated Resident #68 used to have a splint triggering to the ECARE, but it dropped off a while back. Review of the Face Sheet revealed Resident #68 was admitted by the facility on 11/11/20 with diagnoses including Cerebral Palsy and Hemiplegia.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observations, staff interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for a resident dependent on staff for shaving and changing visibly soiled clothing for two (2) of 21 sampled residents. Resident #20 and Resident #44 Findings Include: Review of the facility policy titled Activities of Daily Living undated, revealed, Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . Resident #20 An observation on 7/8/2024 at 11:44 AM, revealed Resident #20 lying in bed, non-communicative with grayish-black facial hair observed above the upper lip, under the lower lip, and to her chin, measuring approximately 1/4 (one-fourth) inch in length. The resident was wearing a hospital gown and had a tan colored liquid substance spread across the chest area of the gown and two (2) small, cubed pieces of carrot. Review of the lunch menu for 7/8/2024 revealed lunch included a hamburger steak with brown gravy over white rice with sliced cooked carrots. An observation and interview with Registered Nurse (RN) #1 on 7/9/2024 at 10:15 AM, confirmed the presence of Resident #20's facial hair and revealed the aides were responsible for shaving the female residents when it was noticeable. RN #1 explained that she glanced into the resident's room daily to ensure her care was completed, and stated she just overlooked the facial hair. She acknowledged that when a resident had soiled clothing, it should be changed immediately. An interview with the Director of Nursing (DON) on 7/9/2024 at 10:21 AM, revealed the aides were responsible for shaving the female residents on their designated bath day. She explained Resident #20 was able to feed herself but was a messy eater. She revealed her expectations were for staff to check for soiled clothing and immediately changed it when needed. Record review of the Face Sheet revealed the facility admitted Resident #20 on 6/29/2023 with medical diagnoses that included Hemiplegia following Nontraumatic Intracerebral Hemorrhage affecting right dominant side. 44804 Resident #44 An observation on 07/08/24 at 2:06 PM revealed Resident #44 sitting in the day room dressed in personal clothes, with a sliced piece of carrot, approximately six (6) pieces of rice and a nickel size amount of a brown substance on her shirt around her chest area. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the lunch menu for 7/8/24 revealed lunch included a hamburger steak with brown gravy over white rice with sliced cooked carrots. An interview on 7/9/24 at 11:00 AM with Certified Nurse Assistant (CNA) #1 revealed that Resident #44 has to be fed by the staff and the resident should always be cleaned up after feeding because this resident cannot clean herself. She stated lunch is served around 11 AM and they should always make sure there is no food left on the resident's clothes after meal time. An interview on 7/9/24 at 11:22 AM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #44 has to be fed by staff and would have been fed by her CNA yesterday. She stated she expects the CNA that feeds the resident to clean the resident up and make sure there is no food left on their clothes from the meal. An interview on 7/9/24 at 1:20 PM with the DON confirmed that Resident #44 has to be fed by the staff and that she normally wears a bib, but she should be checked before leaving the dining room and cleaned to make sure food is not left on the resident. She revealed it was her expectation that would be done for residents. Record review of Resident #44's Face Sheet revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/24 revealed in Section GG that the resident was dependent on staff for eating.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47157 Based on observation, staff interview, record review and facility policy review, the facility failed to provide services to assure a resident maintained the level of range of motion (ROM) for one (1) of three (3) residents positioning and mobility. Resident # 68 Findings include: Review of the policy titled, Contracture Prevention Protocol, revealed Policy: .A resident with a limited ROM (Range of Motion) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM, thus preventing contracture formation . An observation of Resident #68 on 7/8/24 at 11:00 AM revealed the resident's left hand/wrist to be contracted, a splinting device was observed lying on the counter next to the sink. An observation of Resident #68 on 7/8/24 at 2:45 PM revealed a hand splint laying on the counter next to the sink, resident observed with no splinting devices observed on left hand. Interview with Licensed Practical Nurse (LPN) #2 on 7/9/24 at 10:30 AM, confirmed Resident #68 should have been wearing the resting left-hand splint on 7/8/24 but confirmed she did not check to see if the resident was wearing the splint. She then revealed, after reviewing the Treatment Administration Records (TAR) and the physician's orders for Resident #68, that she did not see the order for the splint. An interview with the Occupational Therapist (OT) on 7/9/24 at 10:35 AM, revealed she has not had Resident #68 on case load for a while but confirmed that Resident #68 should be wearing her left-hand splint to prevent worsening of contractures, and she confirmed she had not discontinued the device. Record review of OT notes for Resident #68 revealed she began OT services on 1/2/2022 for functional decline with left-hand contracture, muscle wasting and atrophy after a hospital stay. OT services were discontinued on 2/10/22 related to goals met. Record review of a written Physician's Order for Resident #68 provided by the facility dated 2/10/22 revealed, resident to wear (L) left resting hand splint four (4) hours per day with staff monitoring skin for irritation to decrease risk of worsening joint deformity with no discontinue date. Record review of the July 2024 Physician's Orders for Resident #68 revealed no order for a left resting hand splint. Interview with Restorative Nurse on 7/9/24 at 10:40 AM, she revealed after review of Resident #68's physician's orders, she confirmed she was unable to find the splinting device for the left hand listed at all, and the purpose of the left-hand splint was to prevent worsening of the contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 7/10/24 at 8:30 AM, revealed after further investigation it was found that the order for the left-hand splint was entered into the computer system to alert staff on 2/10/22 when Resident #68 was discharged from OT, but for some reason dropped off in May 2022 and was never re-entered in the computer system. Record review of the Face Sheet revealed Resident #68 was admitted by the facility on 11/11/20 with diagnoses including Cerebral Palsy and Hemiplegia. Record review of Resident #68's Section C of the Minimum Data Set (MDS) revealed that on 6/14/24 the Brief Interview for Mental Status (BIMS) score was 0, indicating the resident was severely cognitively impaired. Section GG0115: Functional Limitation in Range of Motion was coded 1. Impairment on one side to upper extremity.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47157 Based on observations, staff interviews, record review and facility policy review, the facility failed to prevent the possibility of infection as evidenced by failing to cleanse and properly store a Percutaneous Endoscopic Gastrostomy (PEG) tube syringe for (1) one of (5) five resident care observations. Resident # 68 Findings include: Review of the facility policy titled, Standard Precaution, revealed, .Policy Interpretation: Any equipment or items that may be suspected of contamination with body fluids must be handled in a manner to prevent possible transmission of infectious agents . Review of the facility policy titled, Feeding Syringe Policy, revealed, Our policy for the cleanliness of syringes is they are dated and stored on a pole bag. Syringes are stored separated after use. An observation of Resident #68's room on 7/8/24 at 11:00 AM, revealed a PEG tube syringe separated and laying on the bedside table, with no clean barrier or storage bag observed on the table. Interview with Licensed Practical Nurse (LPN) #2 on 7/9/24 at 10:30 AM revealed she was assigned to Resident #68 and confirmed she left the PEG tube syringe laying on the bedside table. She revealed she should have cleansed the syringe, dried it and placed it in a clean storage bag. She then stated that by not cleaning and storing the PEG tube syringe correctly, it placed Resident #68 at increased risk for transmission of bacteria and infection into the gastric site. Interview with the Infection Control Nurse on 7/09/24 at 10:40 AM, revealed that the PEG tube syringe should have been cleaned and dried and stored in a clean storage bag. She stated by not cleaning and storing the PEG tube syringe appropriately, Resident #68 was placed at increased risk for transmission of infection or bacteria and germs to the PEG site. A record review of the July 2024 Physician's Orders for Resident #68 revealed she received all medications, nutrition, and fluid requirements via the PEG tube. Record review of the Face Sheet revealed Resident #68 was admitted by the facility on 11/11/20 with diagnoses including Cerebral Palsy and Encounter for Attention to Gastrostomy.