STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 two (2) Complaint Investigations (CI MS #24068 and CI MS #24293 at the facility from 3/19/24 through 3/20/24. The SA investigated CI MS #24293 related to an allegation of abuse and there were no deficiencies cited related to the complaint. The SA investigated CI MS #24068 related to a resident fall and cited F656 and F689. During the survey, the facility was found to be in compliance with the requirements of participation in Medicare and Medicaid. Based on the facility's implementation of corrective actions completed by 2/8/24, the SA determined this to be Past non-compliance (PNC) as of 2/8/24, prior to the SA's entrance into the facility on 3/19/24. The facility had a census of 116, with a bed capacity of 120.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

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

Electronically Signed | 04/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review the facility failed to implement care plan interventions related to Activities of Daily Living (ADL) care for one (1) of three (3) residents reviewed for care plans. Resident #1. Based on the facility's implementation of corrective actions completed by 2/8/24, the SA determined this to be Past non-compliance (PNC) as of 2/8/24, prior to the SA's entrance into the	F 656	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 2	F 656		

facility on 3/19/24.

Findings Include:

Record review of the facility's policy, "Develop/Implement Comprehensive Care Plan", revised September 2022, revealed, "The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment ..."

Record review of the comprehensive care plan for Resident #1 revealed a care plan with a start date of 1/19/24 revealed "Care Plan Goal I want to be kept clean, dry and needs met ...Intervention ...I require sub/max (submaximal) assist w/ (with) roll left and right in bed ext (extensive) x 2 w/bed mobility)..."

During an interview on 03/19/24 at 11:30 AM, with the facility Administrator (ADM) revealed that the facility had investigated on 02/03/24 and determined that an agency Certified Nursing Assistant (CNA #1) had not followed the resident's care plan and had not requested assistance with the care of the Resident #1. CNA #1 rolled Resident #1 over in his bed and he fell out of bed onto the floor and hit his head and elbow. The facility began in-service training on 02/03/24 and no employee was allowed to work until they were in-serviced on following care plans. The facility had two (2) Quality Assurance Committee meetings from 02/05/24 through 02/08/24. The ADM stated that the facility had put a corrective action plan in place immediately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 3	F 656		

following the incident on 02/03/24 and that the facility had made all corrections for non-compliance by 02/08/24.

During an interview on 03/19/24 at 11:30 AM, with the facility's Director of Nursing (DON) revealed that Resident #1 had always been care planned since his admission several years ago, as a total care resident with two (2) persons to assist with all ADL's. The DON stated that the care plans for all residents are placed in the CNA's hands for review and can be referred to, at any point during a shift, in the CNA 's computer stations. The DON stated that CNA #1 admitted that she had attempted to deliver care to Resident #1 alone and had not attempted to ask for help from the other staff that were present on first shift on 02/03/24.

Interview on 03/19/24 at 1:30 PM, with Resident #1 revealed there was one (1) CNA in the room when he fell from the bed on 2/3/24.

During an interview on 03/20/24 at 12:45 PM, with Licensed Practical Nurse (LPN) #1, Safety Nurse, revealed that CNA #1 had not followed procedures and had solely attempted to care for Resident #1 without following the care plan for a two (2) person assist for all care.

During an interview on 03/20/24 at 12:55 PM, with CNA #2, revealed CNA #1 was alone in the resident's room when she went in to assist Resident #1 from the floor. She stated that CNA #2 had voiced that she thought that she could care for Resident #1 by herself. CNA #2 stated that all the CNA's had access to all resident care plans and Resident #1 had always been a two (2) person assist with all his needs since he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 4	F 656		

admitted to the facility. CNA #2 confirmed that CNA #1 had not followed the care plan of Resident #1 which caused his fall.

Interview on 03/20/24 at 1:10 PM, with Registered Nurse (RN) #1, Treatment Nurse, revealed the entire staff had been in-serviced on following the care plans of all residents and to especially be mindful of residents that need two (2) people to assist with their care.

Interview on 03/20/24 at 2:00 PM, with Registered Nurse (RN) #2, Care Plan Nurse, revealed Resident #1 had been care planned as a two (2) person assist with all his ADL's since he was admitted to the facility. RN #2 stated that CNA #1 had not followed the care plan that was in place for Resident #1 and had caused Resident #1 to fall off the bed onto the floor. RN #2 stated that CNA #1 had access to the care plan of Resident #1 and that she did not follow the ADL interventions to prevent accidents, injuries, and/or falls. RN #2 confirmed that all staff had been in-serviced on following the care plans to prevent accidents since Resident #1 fell on 02/03/24.

Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 11/5/2015 and he had current diagnoses including Paraplegia.

Record review for Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated his cognition was moderately impaired.

The facility began their investigation and corrective actions on 02/03/24 as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 5	F 656		

1-Evaluated/assessed all residents that were assigned to CNA #1's care.
2-Evaluated/assessed Resident #1 and sent him out to the local hospital for further evaluation.
3-Investigated and obtained statements from all staff that worked on 02/03/24.
4-Suspended CNA #1 from the facility at 3:00 PM on 02/03/24.
5-Contacted the contract Nursing agency and terminated CNA #1 from working at the facility.
6-In-serviced all staff concerning fall preventions and following care plans.
7-Completed all plans of action on 02/08/24.
8-Continued ongoing assessments and evaluations of Resident #1 and had reviewed and updated his care plan.
9-Conducted two (2) Quality Assurance (QA) committee meetings from 02/05/24 through 02/08/24.

On 3/20/24 the State Agency (SA) validated through observation, interview, and record reviews that the correction actions were implemented by the facility as follows:

1-The SA validated all residents were evaluated/assessed that were assigned to CNA #1's care.
2-The SA validated Resident #1 was evaluated/assessed and sent out to the local hospital for further evaluation.
3-The SA validated the facility investigated and statements were obtained from all staff that worked on 02/03/24.
4-The SA validated CNA #1 was suspended from the facility on 2/3/24 at 3:00 PM.
5-The SA validated the facility contacted the contract Nursing agency and terminated CNA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 656	Continued From page 6 from working at the facility. 6-The SA validated all staff were inserviced concerning fall preventions and following care plans. 7-The SA validated all plans of action were completed by 02/08/24. 8-The SA validated continued ongoing assessments and evaluations of Resident #1 and validated the facility had reviewed and updated his care plan. 9- The SA validated the facility conducted two (2) Quality Assurance (QA) committee meetings from 02/05/24 through 02/08/24.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to prevent a fall during Activities of Daily Living (ADL) care for one (1) of three (3) sampled residents. Resident #1. Based on the facility's implementation of corrective actions completed by 2/8/24, the SA determined this to be Past non-compliance (PNC) as of 2/8/24, prior to the SA's entrance into the facility on 3/19/24. Findings Include:	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 7	F 689		

Record review of the facility's "Fall Management Policy", updated 01/23/23, revealed, " ...shall strive to maintain an environment that promotes resident safety. Resident assessment and monitoring will help in managing the occurrence of falls ..."

Record review of a handwritten statement signed by CNA #1, dated 2/3/24 at 3:00 PM revealed, " Was wiping Resident down and got sheet wet so want to change sheet. Rolled resident over and couldn't find anyone in hall to stand on other side so when I rolled resident and put sheet under to put new sheet down he started to roll off bed tried to catch but resident slipped out of my hands ..."

Record review of the facility's "Facility Reported Follow-Up Investigation", dated 02/03/24, revealed " ...Resident has 5 small abrasions to left forearm, did not require steri-strips. Blue and dark colored bruising noted to left upper and lower elbow ...No additional physical or mental harm noted ...(Proper name of CNA #1) I was wiping resident down and got sheet wet.Rolled resident over ...he started to roll off bed ..."

Interview on 03/19/24 at 11:30 AM, with the facility Administrator (ADM) revealed that the facility had conducted an investigation on 02/03/24 and determined that an agency Certified Nursing Assistant (CNA #1) had not followed the resident's care plan and had not requested assistance with the care of the Resident #1. CNA #1 rolled Resident #1 over in his bed and he fell out of bed onto the floor and hit his head and elbow. The resident was immediately transported to the local emergency room for evaluation and was found to not have any injuries. The facility called the nursing agency that CNA #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 8	F 689		

employed with and requested that she never return to the facility to work. CNA #1 has not worked at the facility since the incident with Resident #1 on 02/03/24. The facility thoroughly investigated the incident and assessed all residents that had been attended by or assigned to CNA #1. The facility began in-service training on 02/03/24 and no employee was allowed to work until they were in-serviced on following care plans and following ADL protocols as well as abuse, neglect, and exploitation. The facility had two (2) Quality Assurance Committee meetings from 02/05/24 through 02/08/24. The ADM stated that the facility had put a corrective action plan in place immediately following the incident on 02/03/24 and that the facility had made all corrections for non-compliance by 02/08/24.

Interview on 03/19/24 at 11:30 AM, with the facility's Director of Nursing (DON) revealed she was called to the facility on a Saturday 2/3/24 in the afternoon at approximately 2:30 PM and was told that Resident #1 had fallen and hit his head and elbow. Resident #1 was a paraplegic and had no use of his lower extremities and very limited use of his upper extremities. The DON discovered upon her investigation that CNA #1 had not followed facility procedures and had not obtained other staff to help with the care of Resident #1. The DON stated that all residents within the care of the CNA were interviewed and assessed on 02/03/24 and Resident #1 was sent out for x-rays and assessments which determined that he was not in pain and was not injured. He had no injuries. Resident #1 did obtain five (5) small abrasions to his elbow and some bruising to his arm and elbow did appear. Resident's x-rays and CT (computed tomography) scan were negative. The DON stated that CNA #1 admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 9	F 689		

that she had attempted to deliver care to Resident #1 alone and had not attempted to ask for help from the other staff that were present on first shift 02/03/24. CNA#1 had never been employed by the facility but had always been an agency employee.

Interview on 03/19/24 at 1:30 PM, with Resident #1 revealed he remembered how he fell out of bed on 02/03/24. Resident #1 stated, "I was dropped on the floor." Resident #1 stated that he was being attended to by one (1) CNA and he could not remember her name. Resident #1 stated that there was no one else in the room when he "was dropped." Resident #1 confirmed that he fell on the floor and was assisted up by several staff and transported to the local hospital for evaluation. Resident #1 stated that he never had pain and had not taken any pain medications as a result of the fall on 02/03/24. Resident #1 stated that he did not receive any serious injuries as a result of the fall, only small abrasions with some bruises to his elbow and he hit his head.

Interview on 03/20/24 at 12:45 PM, with Licensed Practical Nurse (LPN) #1, Safety Nurse, revealed that she had been a member of the Quality Assurance (QA) Committee meetings and that it was determined through investigation that CNA #1 had not followed procedure and had not obtained assistance from other staff to assist with Resident #1 during care. She stated that Resident #1 fell from the bed to the floor and hit his head and elbow and had been assessed and transferred to the local hospital for evaluation and returned to the facility on the same day with no new orders. LPN #1 stated that she assists in the training and in-services of all staff on safety of the residents and fall precautions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 10	F 689		

Interview on 03/20/24 at 12:55 PM, with CNA #2 revealed that she had been working on 02/03/24 on first shift when Resident #1 fell. CNA #2 stated that CNA #1 called out for assistance and that she and two (2) other nurses came to the room to assist with Resident #1. When she arrived in Resident #1's room he was on the floor on his side as he had fallen off the bed. CNA #1 was alone in the room and had voiced that she thought that she could care for Resident #1 by herself. CNA #2 stated that Resident #1 made no complaints, and he did not moan, groan, or voice and pain or injury. Resident #1 stated that CNA #1 had "dropped" him. CNA #2 stated that Resident #1 was sent out for assessment to the local hospital and was returned the same day with no injuries. CNA #2 stated that on 02/03/24 there were 9 other CNA 's working first shift and two (2) nurse supervisors and four (4) medication nurses. There was no shortage of staff on 02/03/24 during the first shift when Resident #1 fell at approximately 2:00 PM. CNA #2 stated that Resident #1 had always been a two (2) person assist with all his needs since he was admitted to the facility.

Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 11/5/2015 and he had current diagnoses including Paraplegia.

Record review for Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated his cognition was moderately impaired.

The facility began their investigation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 11	F 689		

corrective actions on 02/03/24 as follows:

1-Evaluated/assessed all residents that were assigned to CNA #1's care.
2-Evaluated/assessed Resident #1 and sent him out to the local hospital for further evaluation.
3-Investigated and obtained statements from all staff that worked on 02/03/24.
4-Suspended CNA #1 from the facility at 3:00 PM on 02/03/24.
5-Contacted the contract Nursing agency and terminated CNA #1 from working at the facility.
6-In-serviced all staff concerning fall preventions and following care plans.
7-Completed all plans of action on 02/08/24.
8-Continued ongoing assessments and evaluations of Resident #1 and had reviewed and updated his care plan.
9-Conducted two (2) Quality Assurance (QA) committee meetings from 02/05/24 through 02/08/24.

On 3/20/24 the State Agency (SA) validated through observation, interview, and record reviews that the correction actions were implemented by the facility as follows:

1-The SA validated all residents were evaluated/assessed that were assigned to CNA #1's care.
2-The SA validated Resident #1 was evaluated/assessed and sent out to the local hospital for further evaluation.
3-The SA validated the facility investigated and statements were obtained from all staff that worked on 02/03/24.
4-The SA validated CNA #1 was suspended from the facility on 2/3/24 at 3:00 PM.
5-The SA validated the facility contacted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 689	Continued From page 12 contract Nursing agency and terminated CNA #1 from working at the facility. 6-The SA validated all staff were inserviced concerning fall preventions and following care plans. 7-The SA validated all plans of action were completed by 02/08/24. 8-The SA validated continued ongoing assessments and evaluations of Resident #1 and validated the facility had reviewed and updated his care plan. 9- The SA validated the facility conducted two (2) Quality Assurance (QA) committee meetings from 02/05/24 through 02/08/24.	F 689		