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 _____	10/17/2024

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 an annual recertification survey at the facility from 10/15/24 through 10/17/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F561, F578, F641, F656, F695, F804, and F880. The facility had a census of 109 and was licensed for 120 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		11/27/24

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

Electronically Signed | 11/06/2024

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to honor residents' rights for self-determination by not allowing residents to go outside together for two (2) of 22 sampled residents. Residents #13 and #14. Findings Include: A review of the facility's policy titled "Resident Rights Policy," revised 09/2022, revealed: "...Facility will ensure that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality..." Resident #13: A record review of Resident #13's "Admission Record" revealed the facility admitted the resident on 10/18/21. The resident had diagnoses that included Paranoid Schizophrenia and Neuroleptic Induced Parkinsonism. A record review of Resident #13's "Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/24/24 revealed a Brief Interview for Mental Status (BIMS)	F 561	F561 Self-Determination 1. Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, and Activities Director met with Resident #13 and #14 on October 31, 2024, to discuss Resident□s rights and assure them they are able to sit on the front porch together when they choose to. Residents were instructed to come to the Administrator, Social Services, or Activities personnel if they had any additional issues. Resident #13 was educated by Director of Nursing on October 31, 2024 if Resident #14 needs assistance with positioning he can ask the staff for assistance for both resident□s safety. Resident #13 verbalized understanding. 2. All Residents had the potential to be affected. 3. Self-Determination Audit and In-Service a. Self Determination In-service with staff on Resident□s Rights given by the Administrator and Social Services Director on October 29, 2024 and November 4, 2024 b. Self-Determination In-Service scheduled with Ombudsman on November 14, 2024. 4. Self Determination Audit asking Resident #13 and #14 if they would like to sit on the porch together and ensuring	

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F 561	Continued From page 2	F 561		

Summary Score of 14, which indicated the resident was cognitively intact. Section F indicated that it is very important to Resident #13 to engage in his favorite activities and to go outside for fresh air when the weather is favorable. Section GG revealed no impairment in range of motion for upper or lower extremities and that Resident #13 is independent or requires supervision for Activities of Daily Living (ADLs).

Resident #14:

A record review of Resident #14's "Admission Record" revealed the facility admitted the resident on 09/20/21. The resident had diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis.

A record review of Resident #14's "Annual MDS" with an ARD of 02/27/24 revealed a BIMS summary score of 15, which indicated the resident was cognitively intact. Section F indicated that it is very important to Resident #14 to engage in favorite activities and to go outside for fresh air when the weather is good.

A record review of Resident #14's "Quarterly MDS" with an ARD of 08/13/24, Section GG, revealed that Resident #14 had no impairment in range of motion for upper or lower extremities, used a wheelchair, and was dependent on staff for transfers.

During an observation and interview on 10/15/24 at 11:07 AM, Resident #13 and Resident #14 reported that they wished to go outside together, but were not allowed to do so because Resident #13 had previously tried to assist his wife, Resident #14. As a result, they were no longer

follow through if they choose, to be conducted by Activities Personnel starting on November 1, 2024, to be conducted once daily for one month, then once weekly for one month, then once monthly for three months, for a total of five months. The audit findings will be reported monthly for five months to the Quality Assurance committee to ensure continued compliance beginning November 26, 2024.

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F 561	Continued From page 3	F 561		

permitted to be outside together alone. Resident #13 explained that he was trying to prevent his wife from falling. Resident #14 stated that while they could go outside for activities, they wished to be allowed outside at other times as well. She added that she attends dialysis three (3) times a week, and her husband, Resident #13, attends outpatient therapy three (3) times a week, meaning they are not together daily. Both residents reported that they have asked staff, both during the week and on weekends, to be allowed to go outside together but were consistently told that they could not. Both residents expressed that it is very important to them to spend time together outside and enjoy fresh air.

During an observation on 10/16/24 at 9:20 AM, Resident #13 was not in his room, while Resident #14 was observed still in bed. Resident #13 explained that her husband was away for outpatient services and would return later that day.

During an interview on 10/16/24 at 10:00 AM, Certified Nursing Aide (CNA) #2 in training explained that she had never seen Residents #13 and #14 go outside together. She had been working at the facility since August and had seen Resident #13 go outside by himself but had never seen the two together.

During an interview on 10/16/24 at 11:04 AM, Licensed Practical Nurse (LPN) #4 stated that she was aware that Resident #13 and Resident #14 were not allowed to go outside together. She mentioned that she had been informed by staff that Resident #13 had previously attempted to assist Resident #14 when she almost fell, leading

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F 561	Continued From page 4 to the restriction. During an interview on 10/17/24 at 11:26 AM, Social Services #1 explained that she was unaware of the residents' complaints or that staff were not allowing Resident #13 and Resident #14 to go outside together. She recalled a past incident where Resident #13 tried to help his wife into a van but was not aware of staff preventing the couple from going outside by themselves. She mentioned that the facility employs agency staff and has different personnel on weekends, which might impact consistency. She emphasized that it is the residents' right to go outside when they choose, and she expects all staff to respect residents' rights at all times. During an interview on 10/17/24 at 12:05 PM, the Administrator stated that she was not aware that Resident #13 and Resident #14 were being prevented from going outside together. She emphasized her expectation that staff respect residents' rights at all times. During an interview on 10/17/24 at 2:00 PM, the Director of Nursing (DON) confirmed that she expects all staff to respect and honor residents' rights at all times.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578		11/27/24

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F 578	Continued From page 5 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to ensure that a resident who did not have an advance directive received information or assistance in formulating an advance directive for one (1) of twenty-two	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive 1. Resident #7□s Advanced Directive Acknowledgement Form was completed on October 23, 2024, and is now scanned	

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F 578	Continued From page 6 (22) residents reviewed for advance directives. Resident #7. Findings Include: A record review of the "Admission Record" for Resident #7, revealed an admission date of 10/09/21 with diagnoses including Dysphagia, Dementia, and Alzheimer's Disease. A record review of Resident #7's "Admission Agreement Checklist" dated 10/9/21, revealed that the resident does not have a Power of Attorney (POA) and that the checklist does not indicate acknowledgment of an Advance Directive. During an interview on 10/15/24 at 11:54 AM, Resident #7's Resident Representative (RR) stated that he has not established a Power of Attorney. During a record review of Resident #7's chart, there was no documentation acknowledging the existence of an Advance Directive or a Power of Attorney. During an interview on 10/16/24 at 1:50 PM, the Administrator stated that Resident #7 does not have an Advance Directive Acknowledgment Form or Power of Attorney. She mentioned that while they provided Resident #7's RR with a booklet on Advance Directives upon admission, there was no documentation indicating that the resident acknowledged receiving this information. During an interview on 10/16/24 at 2:10 PM, the Director of Nursing (DON) confirmed that Resident #7 does not have a Power of Attorney or	F 578	into the Electronic Health Record. 2. All Residents had the potential to be affected. 3. Advanced Directive Acknowledgement Form a. Advanced Directive Acknowledgement Form audit of all charts was performed by Social Services to ensure the Advanced Directive Acknowledgement Form was on all Residents□ records on November 1, 2024. Advanced Directive Acknowledgement Forms will be scanned directly into the electronic health record on admission. b. In-service Social Services and Medical Records on importance of Advanced Directive Acknowledgement Form being on all Resident health records. c. Social Services will be responsible for scanning all Advanced Directive Acknowledgement Forms as the Resident□s Quarterly Assessment comes due, until all resident□s Advanced Directive Acknowledgement Forms have been scanned into the electronic health record. 4. Medical Records will audit the chart of all new admissions at 24 hours and 72 hours beginning October 18, 2024, after admission to ensure the Advanced Directive Acknowledgement Form is in the Residents□ electronic health record. This will be an ongoing process. Findings will be reported monthly to the Quality Assurance Committee beginning on November 26, 2024 and monthly thereafter. Social Services will report	

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F 578	Continued From page 7 a copy of the facility's "Advance Directive Acknowledgment Form" in her records.	F 578	monthly to the Quality Assurance Committee on the progress of the scanning in of the Advanced Directive Acknowledgement Form until completed starting November 26, 2024.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, and facility policy review, the facility failed to complete a Minimum Data Set (MDS) discharge assessments accurately for one (1) of twenty-two (22) residents reviewed for assessments. Resident #109. Findings Include: A review of the facility's policy titled "Resident Assessment Instrument (RAI) Policy" (undated) revealed, "It is the policy of the facility that the RAI will be done as follows: According to the guideline specified by: ...Division of Medicaid ..." A record review of Resident #109's "Face Sheet" revealed an admission date of 07/01/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Hypertensive Chronic Kidney Disease, and Hypertensive Heart Disease with Heart Failure. A record review of Resident #109's Discharge MDS with an Assessment Reference Date (ARD) of 08/08/24 revealed that the discharge was	F 641	F641 Accuracy of Assessments 1. Resident #109 Minimum Data Sets Assessment was corrected and re-submitted on October 24, 2024 by the MDS Coordinator. 2. All Residents have the potential to be affected. 3. Assessment Accuracy a. Administrator reviewed Facility Policy on Accuracy of Assessments with MDS staff on November 4, 2024, to ensure policy was being followed. 4. Assessment Accuracy audit will be performed by the MDS Coordinator, starting on November 4, 2024, to audit all assessments once weekly for one month, then every other week for one month, and then once a month for one month, for a total of 3 months. The audit findings will be reported by the MDS Director monthly for three months to the Quality Assurance Committee to ensure continued compliance beginning November 26, 2024.	11/27/24

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F 641	Continued From page 8 coded as a short-term general hospital stay (acute hospital). A record review of Resident #109's "Physician Order Sheet" revealed a physician's order, written on 08/08/24 at 8:53 AM for Resident #109 to " ... (Name of home health) to follow up at home." A record review of the "Departmental Notes" dated 8/8/24 at 9:29 AM and signed by Social Services revealed "MDS discharge assessment completed ...on Thursday, August 8, 2024 ...Resident left facility under the care of family ..." During an interview on 10/17/24 at 1:55 PM, the Registered Nurse/MDS Coordinator stated that the discharge should have been coded as the resident going home. During an interview on 10/17/24 at 2:08 PM, Licensed Practical Nurse (LPN) #3, an MDS nurse, stated that she had incorrectly coded the resident as being discharged to the hospital. She acknowledged that it should have been coded as a discharge to home and explained that she entered the information in error.	F 641		
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	F 656		11/27/24

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F 656	Continued From page 9 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 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 observation, interviews, record review, and facility policy review, the facility failed to	F 656	F656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 10 implement a care plan intervention regarding changing oxygen (O2) tubing for one (1) of twenty-two (22) sampled residents. Resident #76. Findings Include: A review of the facility's policy titled "Comprehensive Resident-Centered Care Plans" (undated) revealed, "... It is the policy of this facility to provide services based on the following requirements ...Development/Implement Comprehensive Care Plan. The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. A review of the facility ' s policy titled "Oxygen Policy" (undated) revealed, "... It is the policy of this facility that oxygen will be utilized as follows: ... with the specific physician orders... Date the tubing ..." A record review of the "Comprehensive Care Plan" with a start date of 3/22/23, revealed Resident #76 had a care plan intervention to "Change my O2 tubing and wash filter every week on Friday." On 10/15/24 at 12:08 PM, during an observation, Resident #76 was observed receiving oxygen via nasal cannula at 2 liters per minute. The tubing was not dated to indicate the tubing had been changed. The resident reported that she must wear oxygen at all times.	F 656	1. Resident #76 Oxygen Tubing was changed and dated on 10/16/2024. 2. All residents who have orders for O2 or respiratory care has the potential to be affected. 3. Development/Implement Comprehensive Care Plan a. Director of Nursing and Assistant Director of Nursing In-serviced Nurses on November 4, 2024 and November 5, 2024 about the importance of following the Care Plan and ensuring tubing is marked with a white label and dated when it is changed. 4. All Care Plans were reviewed on November 5, 2024 for Residents with orders for O2 to ensure facility policy on Oxygen Tubing is being followed. This will be performed monthly by the Director of Nursing. This will be an ongoing process. Findings of Care Plan Review will be reported the Quality Assurance Committee beginning on November 26, 2024 and monthly thereafter.	

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F 656	Continued From page 11 On 10/16/24 at 1:30 PM, during an observation and interview, Registered Nurse (RN) #4 observed and confirmed that Resident #76's oxygen tubing was not dated and stated "the oxygen tubing should be changed weekly and dated." During an interview on 10/17/24 at 2:10 PM, the Minimum Data Set (MDS)/Care Plan Coordinator explained that the purpose of each resident's care plan is to inform staff about how to care for each resident. She emphasized that she expects all staff to follow a resident's care plan to ensure proper care. During an interview on 10/17/24 at 2:25 PM, the Director of Nursing (DON) stated that she expects all staff to follow the resident's care plan when providing care to any resident. A record review of the "Admission Record" revealed that the facility admitted Resident #76 on 01/18/23 with diagnoses including Chronic Diastolic (Congestive) Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24 revealed in Section O of the MDS that Resident #76 received oxygen therapy. A record review of the "Medication Review Report" dated 10/16/24 revealed Resident #76 a physician's order, dated 08/27/24, to change the oxygen tubing and wash the filter every week on Fridays.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		11/27/24

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 _____	10/17/2024

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 695	Continued From page 12 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to follow standards of practice for respiratory care regarding dating and changing oxygen tubing weekly and storing it in a plastic bag when not in use for one (1) of two (2) residents observed for respiratory care. Resident #76. Findings Include: A review of the facility's policy titled "Oxygen Policy," (undated) revealed, "... It is the policy of this facility that oxygen will be utilized as follows: ... With the specific physician orders... Date the tubing ..." A record review of Resident #76's "Admission Record" revealed that the facility admitted the resident on 01/18/23. The resident had diagnoses that included Chronic Diastolic (Congestive) Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation. A record review of Resident #76's "Quarterly Minimum Data Set (MDS)" with an Assessment	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. Resident #76 oxygen tubing was changed and dated on 10/16/2024 and tubing placed in plastic storage when not in use by Staff Development Nurse. 2. All residents who have orders for O2 or respiratory care had the potential to be affected. 3. Respiratory/Tracheostomy Care and Suctioning a. Oxygen Tubing/Nebulizer & Tubing Audit by Infection Prevention Nurse and Director of Nursing on October 22, 2024 and October 23, 2024. b. Director of Nursing and Assistant Director of Nursing In-serviced Nurses on November 4, 2024 and November 5, 2024 ensuring tubing is marked with a white label and dated when it is changed and when tubing is not in use it is to be stored in assigned storage bag. 4. Oxygen Tubing/Nebulizer & Tubing Audit will be performed to ensure tubing is labeled, dated, and bagged if not in use by charge nurse once weekly for 3	

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F 695	Continued From page 13 Reference Date (ARD) of 08/20/24 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 11, which indicated that the resident's cognition was moderately impaired. Section O of the MDS indicated that Resident #76 received oxygen therapy. A record review of Resident #76's 10/16/24 "Medication Review Report," revealed physician orders, dated 8/27/24, to change the oxygen (O2) tubing and wash the filter every week on Fridays. During an observation on 10/15/24 at 12:08 PM, Resident #76 was observed receiving oxygen via nasal cannula at 2 liters per minute. The oxygen tubing was not dated. The resident reported that she must wear oxygen at all times. During an observation on 10/15/24 at 3:00 PM, Resident #76 was observed lying in bed wearing oxygen via nasal cannula. The oxygen tubing was still not dated. During an observation on 10/16/24 at 9:35 AM, Resident #76 was not in her room, and the nasal cannula was observed lying on top of the oxygen concentrator, without any type of storage to prevent contamination of the tubing and nasal cannula. The oxygen tubing continued to be undated. During an observation and interview on 10/16/24 at 1:30 PM, Registered Nurse (RN) #4 observed that Resident #76's oxygen tubing was not dated, nor was there a plastic storage bag present. RN #4 confirmed that oxygen tubing is to be changed weekly, dated, and stored in a plastic bag when not in use.	F 695	months starting on November 1, 2024. All Residents with oxygen tubing will be included in the audit. Oxygen Tubing and Nebulizer & Tubing Audit findings will be reported to the Quality Assurance Committee by the Director of Nursing and Assistant Director of Nursing Monthly for 3 months starting on November 26, 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 _____	10/17/2024

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 695	Continued From page 14 During an interview on 10/16/24 at 1:45 PM, Licensed Practical Nurse (LPN) #5 explained that Resident #76 is to wear her oxygen at all times, especially while in bed, but the resident removes it when attending activities. LPN #5 added that when oxygen is not in use, the tubing should be stored in a plastic storage bag and that all tubing should be changed and dated weekly, with the filter cleaned. She mentioned that either the cart nurse or the treatment nurse is responsible for changing the tubing and cleaning the filter. During an interview on 10/16/24 at 3:15 PM, RN #1 stated that all oxygen tubing should be stored in a plastic bag when not in use, and that the tubing and bag should be changed weekly to minimize infection risks for the resident. During an interview on 10/17/24 at 2:25 PM, the Director of Nursing (DON) stated that she expects all staff to adhere to the facility's policies and procedures and follow standards of practice for all residents receiving respiratory care. She confirmed that oxygen tubing should be changed and dated each Friday and stored in a plastic bag when not in use.	F 695		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		11/27/24

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F 804	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents received meals that were palatable and served at an appetizing temperature for three (3) of ten (10) residents observed for dining. Resident #63, Resident #85, and Resident #90. Findings Include: A review of the facility's policy titled "Meal Service," dated 12/23, revealed: " ...Food will be delivered promptly to ensure safe, palatable, and high-quality food served at the appropriate temperature ...Procedure ...6. Food will be served at palatable temperatures (hot food hot and cold food cold) as discerned by the patients/residents and customary practice ..." Resident #63: During an interview on 10/15/24 at 11:42 AM, Resident #63 stated that he was not pleased with the meals, describing them as "hit or miss" and noting that only one (1) out of (10) meals were good. He explained that by the time food arrived at his room, it was cold, sometimes warm, but often was not warm. During an interview on 10/16/24 at 9:03 AM, Resident #63 stated that his breakfast that morning, which included a biscuit, sausage, eggs, and grits, was lukewarm. He mentioned that the two (2) slices of pizza he had received were also lukewarm, although they tasted acceptable. During an interview on 10/16/24 at 3:10 PM,	F 804	F804 Nutritive Value/Appear, Palatable/Preferable Temp 1. Dietary Manager Spoke with Residents #63, #85, and #90 about meal service on October 22, 2024 to ensure food is palatable and served at an appetizing temperature to ensure them she will make sure their food will be palatable and at an appetizing temperature. 2. All residents who receive food from Dietary Department have the potential to be affected. 3. Nutritive Value/Appear, Palatable/Preferable Temp a. New Recipes were printed on November 5, 2024 from Nutrition Systems that go with the menus for seasoning instructions. The recipes will be kept in the menu books. b. Dietary Manager In-serviced all dietary staff on recipe location and the importance of following recipes on November 5, 2024. Cooks were trained on how to appropriately follow the recipes for seasoning. c. Nurses will help pass out trays to decrease serving time to residents beginning on November 5, 2024. 4. Sample Tray Audit started on November 4, 2024 and will be completed by the Dietary manager twice weekly for 1 month, once weekly for 1 month, and every other week for 1 month, totaling 3 months. Palatable/Preferable Temp Audit to ensure taste and temp is palatable for residents started on November 4, 2024	

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 804	Continued From page 16 Resident #63 recalled his lunch, which consisted of chicken patties, greens, black-eyed peas, and cornbread. He stated that the food was lukewarm, noting that the black-eyed peas were bland and could benefit from added seasoning like ham. He shared that he mixed mayonnaise with his peas to improve the taste. A record review of the "Admission Record" revealed the facility admitted Resident #63 on 02/27/23 with diagnoses including Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/24 revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated he was cognitively intact. Resident #85 During an interview on 10/15/24 at 11:10 AM, Resident #85 stated that the food was either too salty or had no taste. She emphasized that she preferred her food to have more flavor. During an interview on 10/15/24 at 12:20 PM, Resident #85 reported that she had not eaten her lunch because it lacked taste and seasoning. A record review of the "Admission Record" revealed the facility admitted Resident #85 on 11/03/23 with diagnoses including Hypertensive Heart Disease. A record review of the Comprehensive MDS with an ARD of 10/07/24 revealed Resident #85 had a BIMS score of nine (9), which indicated her cognition was moderately impaired.	F 804	will be completed by Activities Director twice weekly for 1 month, once weekly for 1 month, and every other week for 1 month, totaling 3 months. Audit findings will be reviewed by Dietary Manager with Quality Assurance Committee monthly for three months beginning on November 26, 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 _____	10/17/2024

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 804	Continued From page 17	F 804		

Resident #90

During an interview on 10/16/24 at 12:14 PM, Resident #90 stated that the food was bland, had no taste, and was cold. She reported that she did not eat her lunch and instead had her family bring her a meal. She mentioned that she had spoken with the previous Dietary Manager about the food quality, but no improvements were made.

A record review of the "Admission Record" revealed the facility admitted Resident #90 on 08/19/22 with diagnoses including Hypertensive Heart Disease.

A record review of the Annual MDS with an ARD of 09/11/24 revealed Resident #90 had a BIMS score of fifteen (15), which indicated she was cognitively intact.

On 10/16/24 at 10:54 AM, during an observation of food temperature checks, Dietary #1 was observed taking food temperatures at the steam table: Chicken patties: 139° Fahrenheit (F), Black-eyed peas: 140°F, and Greens: 160°F.

During an observation on 10/16/24, meal tray preparation began at 11:05 AM, with Cart #1 and the dining hall service began at 11:05 AM. The dietary staff began plating Cart #6, which was the last meal cart, at 12:08 PM and it was completed at 12:18 PM. All meal carts used to deliver meal trays to residents on the hall were delivered on an open style cart. The cart was transported to the hall and the last tray was delivered as a test tray at 12:33 PM. Dietary #2 took the food temperatures of the test tray which revealed: Chicken patties: 99°F, Turnip greens: 100°F, and

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	255250	A. BUILDING _____ B. WING _____	10/17/2024

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 804	Continued From page 18	F 804		

Black-eyed peas: 85°F. The test tray was sampled and the food was bland and at a lukewarm, non-appetizing temperature.

During an interview on 10/16/24 at 12:45 PM, Dietary #2 confirmed that some of the food was bland and lukewarm. She explained that only salt and pepper were used for seasoning due to the loss of recipes from a previous roof leak. She noted that the open cart system and the time taken for food to reach residents' rooms contributed to the lukewarm temperatures.

During an interview on 10/16/24 at 1:44 PM, Dietary #1 stated that she was still being trained to cook and had not been provided with recipes. She explained that she used only salt and pepper for seasoning, avoiding excess salt due to residents' complaints. She believed that the open carts contributed to the food cooling before reaching residents.

During an interview on 10/16/24 at 2:23 PM, Dietary #3 stated that the kitchen staff were being retrained on meal preparation. She confirmed that Dietary #2 was not certified and that Dietary #1 was still learning cooking techniques.

During an interview on 10/17/24 at 10:45 AM, the Director of Nursing (DON) confirmed that residents had complained about the food being too salty or lacking taste (bland) and that it was often cold. The DON reported this to the Administrator, who was working with the kitchen to address the issues.

During an interview on 10/17/24 at 1:26 PM, the Administrator acknowledged residents' complaints about the salty food but was unaware

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	255250	A. BUILDING _____ B. WING _____	10/17/2024

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

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F 804	Continued From page 19 of complaints about the food's bland taste or temperature. She stated that the facility had contracted with an outside company to train the kitchen staff on proper cooking techniques and recipe use.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		11/27/24

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	255250	A. BUILDING _____ B. WING _____	10/17/2024

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

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F 880	Continued From page 20 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to handle linens in a manner to prevent the possible spread of infection (Resident #12) and	F 880	F 880 Infection Prevention and Control 1. Resident #12 linen was removed from floor. Resident #56 Licensed Practical Nurse (LPN) #4 was in-serviced by the	

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	255250	A. BUILDING _____ B. WING _____	10/17/2024

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 880	Continued From page 21 failed to wear appropriate Personal Protective Equipment (PPE) during administration of a bolus feeding for a resident that required Enhanced Barrier Precautions (EBP) (Resident #56) for two (2) of 22 sampled residents. Findings include: A review of the facility policy titled "Infection Control"," dated 09/2022, revealed: " ...The facility has established and will maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program (IPCP) will include, at a minimum the following elements ...Linens. Personnel will handle, store, process, and transport linens so as to prevent the spread of infection ..." A review of the facility's policy "Enhanced Barrier Precautions" dated 03/13/24 revealed " ... Use of Enhanced Barrier Precautions can effectively reduce the spread of Multi-drug resistant Organism (MDRO), specifically those CDC (Center for Disease Control and Prevention) targeted organisms ... Definition: Enhanced Barrier Precautions: include use of gowns and gloves for those residents that would not already be in Contact Precautions. It also could include eye covering if there is an anticipation of a splash ... Indwelling medical device: Devices such as central lines, PICC (Peripherally inserted central catheter) lines, urinary catheters, feeding tubes, tracheostomy/ventilator require EBP ..." Resident #12	F 880	Infection Prevention Nurse on October 30, 2024 on Facility Policy for Enhanced Barrier Precautions. 2. All residents have the potential to be affected 3. Infection Prevention and Control a. Hospice Certified Nursing Assistant responsible for putting linen on floor for resident #12 was in-serviced by Infection Prevention Nurse on November 1, 2024. b. Resident #56 Licensed Practical Nurse (LPN) #4 was in-serviced by the Infection Prevention Nurse on Enhanced Barrier Precautions and following our infection prevention plan for Enhanced Barrier Precautions by wearing the appropriate Personal Protective Equipment when conducting a bolus feeding. c. Enhanced Barrier Precautions instructional flyers were placed on doors of residents requiring Enhanced Barrier Precautions for care and at each nurse□s station for reference for all staff. d. Appropriate multi purpose bags were placed in each residents room to put dirty or soiled linen in. e. Infection Prevention Nurse in-serviced staff on 10/16/2024 on proper Enhanced Barrier Precautions and proper dirty or soiled linen handling. 4. Soiled Linen Audit put in place on November 5, 2024, for Charge nurse to ensure proper linen handling to be completed twice weekly for 1 month, then once weekly for 1 month, and then every other week for 1 month, for the total of 3 months. Enhanced Barrier Precautions Audit put in place on November 5, 2024,	

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	255250	A. BUILDING _____ B. WING _____	10/17/2024

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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F 880	Continued From page 22 During an observation and interview on 10/16/24 at 10:07 AM, Certified Nurse Aide (CNA) #1 had completed incontinence care on Resident #12. There were dirty linens and a soiled brief directly on the floor of the resident's room. She confirmed she had placed the dirty items on the floor and agreed they should not have been placed directly onto the floor. During an interview on 10/16/24 at 2:10 PM, Licensed Practical Nurse (LPN) #2, confirmed CNA #1 should not have placed the dirty linens and brief directly onto the floor. During an interview on 10/16/24 at 2:27 PM, Registered Nurse (RN) #1, the Infection Preventionist (IP), explained that dirty linens should not be on the floor because it could cause infection to be spread to the residents. During an interview on 10/16/24 at 2:48 PM, the Director of Nursing (DON) stated that dirty linens should not come in contact of the floor due to infection control concerns. A record review of Resident #12's "Admission Record" revealed that the facility admitted Resident #12 on 03/10/21 with diagnoses including Type 2 Diabetes Mellitus. Resident #56 During an observation on 10/16/24 at 09:25 AM, Resident #56 was lying in bed and there was signage on the resident's room door that indicated he required EBP. On 10/16/24 at 11:00 AM, during an observation and interview, LPN #4 administered Resident	F 880	to monitor designated Enhanced Barrier Precaution rooms by Infection Prevention Nurse for proper donning and doffing of Enhanced Barrier Precautions twice weekly for 1 month, then once weekly for 1 month, and then every other week for one month for the total of 3 months. Audit findings will be reported to the Quality Assurance Committee by the Infection Prevention Nurse once a month for 3 months starting on November 26, 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 _____	10/17/2024

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 880	Continued From page 23	F 880		

#56's bolus feeding per a Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #4 wore gloves while administering the feeding and did not have a gown on. She stated that because there was no chance of being splashed, she was required to only wear gloves. She confirmed the signage on the resident's door indicated that gloves and gowns should be worn, but reiterated that she had been instructed that she only needed to wear gloves.

On 10/16/24 at 03:30 PM, during an interview with RN #1, she confirmed a gown, and gloves were required to be worn when administering feedings or medication via a PEG tube. She also confirmed the facility's policy and the signage on the door indicated the correct PPE worn for EBP (gown and gloves).

At 02:15 PM on 10/17/24, during an interview with the DON, she confirmed the staff should wear a gown and gloves for residents with peg tubes. She stated she expected all staff to follow the facility's policies and procedures regarding EBP.

A record review of the "Admission Record" revealed the facility admitted Resident #56 on 04/15/24 with diagnoses including Encounter For Attention To Gastrostomy and Gastrostomy Status.

A record review of the "Medication Review Report" revealed Resident #56 on had a Physician's Order, dated 9/3/24, for " ...Enhanced Barrier Precautions D/T (due to) Feeding Tube ..."

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/24 revealed in Section K that

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 _____	10/17/2024

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 880	Continued From page 24 Resident #56 had a feeding tube.	F 880		