Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 3/30/26 to 4/1/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements, and cited M500, M615, M645, M655, M715, M815, M970, and M1570.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall	M0500		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 1 not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 2 and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 3 decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interviews, record review and facility policy review the facility failed to ensure informed consents were obtained before initiation of psychotropic medication (Resident #4, #6, #10, #12, and #92) and failed to ensure residents were recognized for dignity and individuality, including privacy in treatment and in care for personal needs. (Resident #3, and #90) Findings Include: Record review revealed that the facility did not have a policy and provided a statement on letterhead signed by the Administrator dated 03/31/26 "(Proper name of the facility) does not currently have a Psychotropic Consent Policy." Resident #4 Record review of the Order Summary Report revealed a physician's order dated 2/13/2026 for Zyprexa oral tablet 5 milligrams (mg) give 5 mg by mouth at bedtime for schizoaffective disorder. Record review revealed a lack of consent forms for psychotropic medications were signed prior to initiation. Record review of the Admission Record revealed that Resident #4 was admitted to the facility on 10/19/2017 with a medical diagnosis that included schizoaffective disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/2026 revealed a Brief Interview for Mental Status score (BIMS) indicating that the resident was rarely/never understood. Resident #6 Record review of the Order Summary Report revealed a physician's order dated 9/18/25 for Olanzapine tablet 5 mg give 1 tablet by mouth two times a day for affective mood disorder, and a physician's order dated 1/15/26 for Zoloft oral tablet 50 mg give 1 tablet by mouth one	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 4 time a day for depression. Record review revealed a lack of consent forms for psychotropic medications were signed prior to initiation. Record review of the Admission Record revealed that Resident #6 was admitted to the facility on 2/10/25 with medical diagnoses that included Major Depressive Disorder, Unspecified Mood Disorder, and Generalized Anxiety Disorder. Record review of the MDS with an ARD of 2/12/26 revealed a BIMS score of 10, indicating that the resident was moderately impaired with cognition. Resident #10 Record review of the Order Summary Report revealed physician's orders dated 12/11/25 for Trazadone 50 mg give one tablet by mouth one time a day for depression and Risperidone 0.25 mg give one tablet by mouth at bedtime for depression. Record review revealed a lack of consent forms for psychotropic medications were signed prior to initiation. Interview with the Director of Nursing (DON) on 03/31/26 at 12:25 PM stated, "I'm going to be honest we haven't been doing the consent forms. I just discovered this a few weeks ago at a meeting that we weren't doing them and we should have been." Record review of the Admission Record revealed that Resident #10 was admitted to the facility on 05/24/24 with diagnosis that included Unspecified Dementia, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. Record review of the MDS with an ARD of 03/05/26 revealed a BIMS score of 03 indicating that the resident was severely impaired with cognition. Resident #12 Record review under the Order Summary Report revealed a physician's order dated 12/15/2025 for Quetiapine Fumarate oral tablet 100 MG, give 1 tablet by mouth at bedtime for affective disorder, bipolar, give with 200 mg to equal total of 300 mg at bedtime, a physician's order dated 12/15/2025 for Seroquel XR oral tablet extended release 24 hour 200 MG (Quetiapine Fumarate),	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 5 give 1 tablet by mouth at bedtime for affective disorder, Bipolar Disorder take with the 100 mg for a total of 300 mg, and a physician's order dated 2/02/2026 for Risperdal oral tablet 1 mg, give 1 tablet by mouth two times a day for anxiety. Record review revealed that a lack of consent forms for psychotropic medications was signed prior to medication initiation. Record review of the Admission Record revealed that Resident #12 was admitted to the facility on 7/11/2024 with medical diagnoses that included schizoaffective disorder and dementia. Record review of the MDS with an ARD of 1/09/2026 revealed a BIMS score of 11, indicating that Resident #12 had moderate impaired cognition. Resident #92 Record review under the Order Summary Report revealed a physician's order dated 8/28/25 for Alprazolam oral tablet 0.5 mg give 1 tablet by mouth at bedtime for anxiety, Seroquel oral tablet 100 mg give 1 tablet by mouth at bedtime for Dementia illness with associated behavioral symptoms, Sertraline HCl oral tablet 100 mg, give 1 tablet by mouth one time a day for Depression, and an order dated 2/27/26 for Trazodone HCl tablet 100 mg, give 1 tablet by mouth at bedtime for Depression. Record review revealed that a lack of consent forms for psychotropic medications was signed prior to medication initiation. Record review of the Admission Record revealed that Resident #92 was admitted to the facility on 8/28/25 with medical diagnoses that included Major Depressive Disorder, Unspecified Dementia Anxiety Disorder, and Insomnia. Record review of the MDS with an ARD of 3/3/26 revealed a BIMS score of 7, indicating that Resident #92 was moderately impaired with cognition. Resident #3 Review of the facility policy titled “Dignity and Respect," undated, revealed, "Each resident at the facility has the right to a dignified existence..." During an observation on 3/30/26 at 9:50 AM, Resident #3 was noted to have a urinary catheter drainage bag containing approximately 100 cubic centimeters (cc) of	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 6 yellow urine hanging on the lower left side of the bed. The drainage bag was not placed in a privacy bag and was clearly visible to anyone entering the room. During an observation and interview on 3/30/26 at 9:56 AM, the Quality Assurance (QA) Nurse responded to the resident's call light and confirmed the urinary catheter drainage bag was not placed in a privacy bag. The QA Nurse acknowledged that the exposure of the drainage bag constituted a dignity concern for Resident #3. Record review of the “Admission Record” revealed the facility re-admitted Resident #3 on 1/31/26 with medical diagnoses that included Pressure ulcer of sacral Region, Stage 4, Heart failure, Chronic Obstructive Pulmonary Disease, and chronic kidney disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 10, indicating Resident #3 was moderately cognitively impaired. Resident #90 Record review of the facility policy titled “Dignity and Respect” undated revealed under, “...5. Residents will be examined and treated in a manner that maintains bodily privacy. A closed door and/or drawn cubicle curtain should be utilized to maximize the privacy of each resident while rendering care...” Record review of Resident #90’s “Treatment Administration Record” revealed an order dated 3/17/26, “Left heel, cleanse with wound cleanser, apply collagen to wound bed, cover with bordered foam dressing every day shift for stage 3 pressure injury.” During an observation of Resident #90’s wound care on 3/31/26 at 2:58 PM with the Wound Nurse, she performed wound care to the resident’s left heel and pulled the resident’s brief down to assess the skin on the resident’s buttocks without shutting the window blind for privacy. The window was visible from the courtyard, where another resident and one staff member were outdoors during this time. An interview with the Wound Nurse on 3/31/26 at 3:12 PM confirmed she did not close Resident #90’s blind prior	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0500	Continued from page 7 to rendering care. She stated the blind should be closed for the resident's privacy. Record review of the "Admission Record" revealed the facility admitted Resident #90 on 3/16/26 with medical diagnoses including Nondisplaced Zone I Fracture of Sacrum, Pressure Ulcer of Left Heel, Stage 3, and Pressure Ulcer of Left Buttock, Stage 1. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/23/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #90 was cognitively intact.	M0500		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on resident and staff interviews, observation, record review and facility policy review, the facility failed to ensure interventions were maintained to prevent the recurrence of a pressure injury for one (1) of 18 sampled residents. Resident #3 Findings include: Review of the facility policy titled "Pressure Injury Prevention Guidelines" undated, revealed, "Inspect skin while providing care ...Pressure Relieving Devices:.. 6. Provide alternative support surfaces as needed. Considerations for utilizing specialized support surfaces:..a. Medical condition and weight...e. Stage 3, 4, unstageable, or deep tissue injury on trunk..." Record review of the "Wound Care Note" dated 2/4/26, by the Wound Care Family Nurse Practitioner (FNP), revealed "Resident #3 had a Stage 4 pressure injury to the sacrum that was documented as a status of healed." Record review of the "Wound Care Note" dated 3/25/26, by the Wound Care FNP, revealed "...being seen for evaluation of a re-opened Stage 4 sacral wound...."	M0615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0615	Continued from page 8 Record review of the "Order Summary Report" revealed a Physician Order dated 3/23/26 for "Sacrum, Cleanse with wound cleanser, apply Medi honey to wound bed, cover with calcium alginate, secure with bordered foam dressing, every day shift for Stage 4 pressure injury," During an interview on 3/31/26 at 8:55 AM, Resident #3 expressed frustration and sadness that his previously healed wound had reopened, stating the “button on that pump wasn’t set right,” referring to his air mattress on his bed. He reported that the Treatment Nurse informed him his wound had reopened and that his skin was blistered on his bottom. Resident #3 further revealed the Treatment Nurse instructed him to ensure that when anyone entered his room, they did not bump the pump at the end of the bed and that it remained on. During an interview on 3/31/26 at 10:35 AM, Licensed Practical Nurse (LPN) #3 revealed the resident’s air mattress had been mistakenly set to the “static” setting, which made the mattress firm and eliminated the alternating pressure function. She stated she believed that during care, when staff repositioned or pulled the resident up in bed, the increased firmness contributed to friction and resulted in the wound reopening. During an interview on 3/31/26 at 11:10 AM, the Director of Nursing (DON) confirmed the resident’s wound had previously healed but reported receiving a text message from the Treatment Nurse on March 23, 2026, indicating that the wound had reopened and that the mattress had been set to “static,” preventing proper pressure redistribution. During a subsequent interview on 3/31/26 at 12:29 PM, the DON revealed that, according to facility body audits, there were no documented skin concerns after the wound had resolved on 2/2/26. The DON acknowledged that failure to ensure proper use and monitoring of pressure-relieving equipment could place the resident at risk for further skin breakdown. During an interview on 3/31/26 at 2:30 PM, the Treatment Nurse confirmed Resident #3 had a prior sacral pressure injury that was healed and resolved on 02/2/26. She reported that on 03/23/26, she was called to assess the resident after he complained of discomfort to his buttocks. Upon entering the room, she immediately assessed the control box of the resident’s air mattress and observed it was set to “static” mode at a weight setting of 260. She explained this setting results in a fully firm surface and eliminates the	M0615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0615	Continued from page 9 alternating pressure function necessary for pressure redistribution. She stated, “I don’t like this control box because it is so easy to be manipulated—someone can easily bump into it and change the settings.” During an interview on 3/31/26 at 3:00 PM, Certified Nurse Aide (CNA) #2 confirmed the resident previously had a significant pressure ulcer to the sacral area that had healed and stated, “He was doing good.” She further revealed the wound had since reopened and reported she had heard it was related to the air mattress controls not being set correctly. During an interview on 4/1/26 at 10:05 AM, CNA #1 revealed she was providing care to the resident on the day the incorrect mattress setting was identified, and the wound was noted to have reopened. She confirmed the Wound Nurse assessed the pump and instructed staff to ensure the yellow light was not activated, as it caused the mattress to become firm. CNA #1 stated the Wound Nurse explained that having the mattress set incorrectly “defeated the purpose of having an air mattress if it was not working the way it should.” Record review of the “Admission Record” revealed the facility re-admitted Resident #3 on 1/31/26 with medical diagnoses that included Pressure ulcer of sacral Region, Stage 4, Heart failure, Chronic Obstructive Pulmonary Disease, and chronic kidney disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 10, indicating Resident #3 was moderately cognitively impaired.	M0615		
M0645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, staff interviews,	M0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0645	Continued from page 10 and facility policy review, the facility failed to ensure a resident received an ordered supplement to prevent weight loss for one (1) of four (4) residents reviewed for nutrition. Resident #8. Findings Include: Record review of facility policy titled "Weight Policy" with no date, revealed, "The facility shall evaluate a resident with significant weight changes to identify clinical conditions and risk factors that place the resident at risk for unintended weight change and initiate interventions if needed..." A dining observation of Resident #8 on 3/30/2026 at 11:30 AM revealed no nutritional supplement that was ordered was present on the lunch meal tray. The meal included barbecue chicken, sweet peas, potato salad, garlic bread, peach cobbler, and four (4) ounces (oz) of apple juice. Record review revealed a diet order of Controlled Carb Diet (CCD), No Added Salt (NAS), and Super Pudding to lunch and supper meals. An interview with Quality Assurance (QA) nurse on 3/30/2026 at 11:32 AM revealed that the super pudding was on back order, and she confirmed that is the reason that the resident did not have it on his meal tray. Record review revealed the physician order for the super pudding was received and entered on 2/27/2026. An interview with the Dietary Manager on 3/31/2026 at 3:15 PM confirmed that the super pudding was on back order. She revealed that the super pudding had been on back order for three (3) weeks. She revealed that she notified the QA nurse that the super pudding was on back order. She confirmed that Resident #8 had not received an alternative for the super pudding. Interview with QA nurse on 3/31/2026 at 3:25 pm revealed she did not communicate with Registered Dietician (RD) that the super pudding was on back order. QA nurse stated she called and confirmed with the RD that she had not been notified of the super pudding being on back order so she could offer another supplement. Record review of Resident #8's weights revealed on 01/01/2026 the resident weighed 160 pounds (lbs.). On 02/01/2026 the resident weighed 155 lbs. On 02/10/2026 the resident weighed 145 lbs. On 03/01/2026 the resident weighed 148 lbs. Record review of recipe report titled "Pudding, Super -	M0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0645	Continued from page 11 Fortified Foods" revealed the super pudding contains 220 calories, 30 grams of carbohydrates, 6 grams of protein, and 9 grams of fat. Record review of the RD progress notes revealed on 03/24/2026, Resident #8 triggered for significant weight loss of 4.5% in 30 days. She stated the resident is newly started on dialysis which may result in weight loss due to removing excess fluid. Resident's weight was 148 lbs. Resident on CCD/NAS, Regular diet with excellent intake. Consuming 80% (percent) of meals to meet nutritional needs. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 11/06/2025 with medical diagnoses that included Muscle Weakness (Generalized) and Chronic Kidney Disease, unspecified. Record Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 04, indicating Resident #8 was severely cognitively impaired.	M0645		
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interviews, record review, and respiratory therapist interview, the facility failed to ensure physician-ordered settings and proper oxygen integration for a Trilogy ventilator for one (1) of two (2) residents reviewed for respiratory care. Resident #100 Findings Include: The facility provided a statement on letterhead that read, “(Proper name of the facility) does not currently have a policy in place to obtain Physician Orders regarding Trilogy settings.” During an observation on 3/30/2026 at 9:59 AM, Resident	M0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0655	Continued from page 12 #100 was observed lying in bed with the head of the bed elevated and extremely short of breath (SOB) with rapid respirations. Oxygen was in place at 3 liters by nasal cannula. A Trilogy ventilator was observed sitting on the table beside the bed without an oxygen enrichment line connected to the device. An observation on 3/31/26 at 8:02 AM revealed Resident #100's Trilogy machine did not have an oxygen enrichment line attached to the device. Record review of Resident #100's "Order Summary report" revealed an order dated 3/20/26, "Apply Trilogy Q (every) HS (hour sleep) at bedtime" without physician-ordered settings or a physician order instructing staff to ensure oxygen was connected (bled) to the machine at the physician-ordered rate per minute. Further review revealed an order dated 3/19/26, "Oxygen at 3 (three) LPM (liters per minute) per NC (nasal cannula) every shift." An interview with Licensed Practical Nurse (LPN) #2 on 3/31/26 at 10:36 AM revealed Resident #100 wears the Trilogy at night and stated the settings for the Trilogy should be in the orders; however, upon review, she confirmed the resident did not have physician orders for the settings. LPN #2 stated she could ask the resident what his settings were and, if the resident could not remember, she would call the physician. An interview with LPN #4 on 3/31/26 at 10:45 AM revealed Resident #100 brought the Trilogy machine from home with pre-set settings. She confirmed there was not a physician order for the settings and that staff had not verified the programmed settings for accuracy. An interview with the Director of Nursing (DON) on 3/31/26 at 11:01 AM revealed there were no physician orders for the settings because "they don't do that" and confirmed there was no process in place to ensure Resident #100 was receiving the correct settings because the machine came to the facility pre-set by the medical equipment provider. She confirmed the resident could experience respiratory distress if he was not receiving the correct settings along with the correct method of oxygen delivery.	M0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0655	Continued from page 13 A telephone interview with “Proper name of medical equipment supplier” Respiratory Therapist (RT) on 3/31/26 at 1:46 PM revealed she was contacted by the facility to evaluate the Trilogy machine today and she had not previously assessed the machine. The RT confirmed the facility should have ventilator settings in place to verify the parameters prescribed by the physician. She revealed the machine required oxygen to be bled into the device, between 2–4 liters per the resident’s physician order and observed the machine did not have an oxygen enrichment line connected at the time of assessment today. She explained that failure to connect oxygen to the device had the potential to cause respiratory distress and low oxygen levels. She explained that she added the oxygen adapter line to the device today. Record review of the “Admission Record” revealed the facility admitted Resident #100 on 3/19/26 with medical diagnoses that included Acute Respiratory Failure with Hypercapnia and Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 5, which indicated Resident #100 was severely cognitively impaired.	M0655		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure insulins were properly stored in accordance with manufacturer's guidelines to maintain safety and effectiveness for one (1) of two (2) medication carts observed. 300 hall Findings Include: Review of the facility policy titled “Insulin Pen,” with no date, revealed, “…Insulin pens should be disposed of after 28 days…”	M0715		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0715	Continued from page 14 An observation of the 300 hall medication cart on 3/31/26 at 10:50 AM, with Licensed Practical Nurse (LPN) #1, revealed the following insulins were in use and were not dated when opened: Resident #2 – Lantus SoloStar that was undated. Resident #4 – Basagalar KwikPen and Tresiva FlexTouch that was undated. Record review of the “Insulin 28 Day Expiration Date Calculator” with no date revealed, “…Discard multi-dose vials 28 days after initially opening…” Record review of “In-Service: Medication Pass – Tips for Success” with no date revealed, “…Insulin…Ensure that insulin vials are dated when opened…” An interview with LPN #1 on 3/31/26 at 10:52 AM revealed that all insulins, vials or pens should be dated when opened. She stated there would be no way to determine if the insulin was still safe to administer. An interview with the Director of Nursing (DON) on 3/31/26 at 11:15 AM revealed that all insulin stored on medication carts should be checked by nursing staff to ensure they are labeled with an open date.	M0715		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Widespread Based on observations, interviews, and facility policy review, the facility failed to label and store food properly for one (1) of two (2) kitchen tours. Findings include: Review of facility policy titled “Storage of Refrigerated Food” revised 11/23, revealed, “…All opened foods are labeled with common name of food and date stored and/or use-by date…”	M0815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0815	Continued from page 15 During the initial kitchen tour with the Dietary Manager (DM) on 3/30/26 at 9:12 AM several observations were made regarding food storage practices. In reach-in cooler number one (1), several items, including sliced tomatoes, sliced cheese in a clear container, a five (5) gallon container of pasta salad, a one gallon container of sweet and sour sauce, a four (4) pound (lb.) uncovered container of sweet cornbread, 12 boiled eggs, one gallon of liquid seasoning sauce, one gallon of sweet pickle relish, one gallon of BBQ sauce, one gallon of jalapeno peppers, and one gallon of apple cider vinegar were present without dates indicating when they were opened or when they expired. In reach-in cooler number two (2), several items, including 46-ounce (oz.) containers of prune juice, grape juice, and tomato juice; one half gallon of buttermilk, two one-gallon jugs of whole milk, and a one-gallon jug of sweet tea were also present without dates indicating when they were opened or when they expired. During an interview on 3/30/26 at 9:46 AM with the Dietary Manager, she confirmed that no open food items should be stored without an open date and confirmed that the facility policy mandates that all open food items be labeled with an open date for safety and organization.	M0815		
M0970	45.33.4 Control of insects, rodents, etc. Control of insects, rodents, etc. The facility shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods for their eradication and control shall be utilized. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Widespread Based on observations, interviews, and facility policy review, the facility failed to maintain effective pest control management by preventing pests from entering the food and nutrition service department for one (1) of two (2) kitchen tours. Findings included: Review of facility policy titled “Pest Control” revised 8/17, revealed, “Policy: In order to maintain a safe and sanitary environment, a pest management program is used to prevent pests from entering the food and nutrition service department and to implement measures to eliminate any pest infestations…” During the initial kitchen tour with the Dietary	M0970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0970	Continued from page 16 Manager (DM) on 3/30/26 at 9:12 AM, multiple flies were observed randomly flying around in the kitchen prep and cook area and a cockroach was noted crawling on the floor in the dietary manager's office. During an interview on 3/30/26 at 9:12 AM, the Dietary Manager confirmed that the presence of pests (flies and roaches) was unsanitary and they should not be present in food prep or food storage areas.	M0970		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interviews, and facility policy review the facility failed to implement and maintain an effective infection prevention and control program to prevent the spread of infection. This was evidenced by failure to utilize Enhanced Barrier Precautions (EBP) during high-risk care and failure to maintain urinary catheter equipment in a manner to prevent contamination for three (3) of 18 sampled residents. (Resident #2, #13, and #77). Findings Include:	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M1570	Continued from page 17 Review of facility policy titled "Enhanced Barrier Precautions" dated 4/1/2024, revealed, "Policy: It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms..."Enhanced barrier precautions" refer to the use of gown and gloves for certain residents during specific high-contact resident care activities...An order for enhanced barrier precautions will be obtained for residents with any of the following:...feeding tube...High-contact resident care activities...device care or use...feeding tube..." Record review of facility policy titled, “Appropriate Use of Indwelling Catheters” undated revealed, “...It is the policy of this facility to ensure residents with urinary incontinence: … receives appropriate treatment and services to prevent urinary tract infections … All catheters must have leg strap or securement devices in place, privacy bag in use, tubing placement to prevent backflow into bladder, and while in chair or wheelchair tubing must not touch floor with privacy bag in use.” Resident #2 During an observation of catheter care on 4/01/2026 at 8:40 AM for Resident #2 with Certified Nursing Assistant (CNA) #3 and CNA #4, it was observed that they failed to use EBP while performing suprapubic catheter care. Record review of the Order Summary Report revealed an order dated 11/13/2025 for Enhanced Barrier Precautions due to suprapubic catheter. During an interview on 4/01/2026 at 9:00 AM with CNA #3, she confirmed that EBP should have been used during catheter care for residents with catheters. She further stated that EBP was ordered to help prevent the spread of infection. During an interview on 4/01/2026 at 10:00 AM with the Director of Nursing (DON), she stated EBP should be used with any tubes or wounds to prevent possible cross contamination. She further stated that her expectations were for staff to follow EBP with all care provided for residents with a tube or wound. Record review of the Admission Record revealed that Resident #2 was admitted to the facility on 12/13/2024, with medical diagnoses that included urinary tract infection and retention of urine.	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M1570	Continued from page 18 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/15/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #2 was cognitively intact. Resident #13 During observation of Percutaneous Endoscopic Gastrostomy (PEG) medication administration for Resident #13 on 3/31/2026 at 12:17 PM, Licensed Practical Nurse (LPN) #3 failed to use EBP during care. Upon interview immediately following care, LPN #3 realized she failed to wear her gown. She stated, "I just forgot. We are supposed to wear the gowns because of germs. We are supposed to wear them with feeding tubes, catheters, etc." During an interview on 3/31/2026 at 12:27 PM with the DON she confirmed that EBP should be worn during PEG medication administration to help prevent the spread of infection. Record review of the "Admission Record" indicated that the facility admitted Resident #13 on 10/27/2022 with medical diagnoses that included Cerecral Infarction, unspecified. A record review of the MDS with an ARD of 1/17/26 revealed under section C, a BIMS was not attempted because Resident #13 was rarely or never understood. Resident #77 During an observation on 3/30/26 at 10:40 AM, Resident #77 was observed sitting in a wheelchair with an indwelling Foley catheter in place. The urinary catheter tubing was observed exposed, visibly unsecured, and in direct contact with the floor beneath the wheelchair. During a subsequent observation on 3/30/26 at 11:55 AM, Resident #77 was observed propelling himself in a wheelchair through the dining room. The Foley catheter tubing was observed, dragging on the floor underneath the wheelchair. On 3/31/26 at 10:35 AM, Resident #77 was observed sitting in his wheelchair in the doorway of his room. The Foley catheter tubing was observed hanging down and resting on the floor. During an observation and interview on 3/31/26 at 11:35 AM, Resident #77 was observed sitting at a dining room table with the urinary catheter tubing touching the	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M1570	Continued from page 19 floor. At that time, the DON confirmed the catheter tubing was lying on the floor, acknowledged this as an infection control concern, and stated, “the tubing should be properly secured under the wheelchair to prevent contact with the floor.” During an interview on 03/31/26 at 3:15 PM, the Infection Preventionist confirmed that urinary catheter tubing should be maintained off the floor and properly secured to prevent contamination and reduce the risk of infection. Record review of the “Admission Record” revealed the facility admitted Resident #77 on 7/23/25 with medical diagnoses that included Retention of Urine and Acute Kidney Failure. Record review of the MDS with an ARD of 1/26/26 revealed under Section C, a BIMS summary score of 9, indicating Resident #77 was moderately cognitively impaired.	M1570		