STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS Care Center of Alcorn County, Inc-Snf	3701 Joanne Drive Corinth, MS 38834

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on record reviews, staff interviews and facility policy review, the facility failed to ensure a resident's right to be free from abuse and neglect as required for one (1) of 20 residents reviewed. Resident A. Cross Reference F609, F656, F697 Findings Include: Review of facility policy Freedom from Abuse, Neglect and Exploitation revised October 2022 revealed Policy Statement: All residents of this facility have the right to be free from neglect .Residents must not be subject to abuse by anyone .Practices of omitting part of resident care or neglecting resident and misappropriation of property is to be considered as leading to abuse and should be investigated and treated as abuse. A record review of the Grievance/Complaint Report documented by Social Services on 10/22/24 revealed that Resident A reported that staff was rude to him and refused to give him his medications, stating it was bad for him and that he did not need it. He further reported that staff threw his call light on the floor, refused to assist him onto the bedside commode, and that he was scared. A record review of the Record of Complaint documented by the Director of Nursing (DON) on 10/21/24 indicated that Resident A's responsible party stated that the night shift nurse was rude and hateful. The resident expressed a desire to discharge home, stating he felt unsafe and was not receiving proper care at night. The investigation found that the resident's pain was left untreated, and staff interviews revealed examples of misconduct toward resident by the nurse. The immediate corrective actions at the time of the incident included the termination of the night shift nurse, relocating the resident to a different hall per his request, and in-servicing staff on professional conduct, abuse, and neglect. A record review of the Witness Statement documented by the Physical Therapy Assistant (PTA) on 10/21/24 revealed that Resident A stated he wanted to leave the facility. The resident became emotional and expressed fear, stating he had no defense and could not protect himself. He also reported that no one answered his call light, that staff threw it on the floor, and when he asked for it back, they refused, telling him he did not need it. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the PTA on 1/29/25 at 9:25 AM, she confirmed that her statement accurately reflected what Resident A had reported to her on 10/21/24. A record review of a Witness Statement documented by Licensed Practical Nurse (LPN) #2 on 10/22/24 revealed that she heard LPN #3 yelling, Shut up! down the hall on 10/19/24 while Resident A was calling for help. She also stated that LPN #3 said she was not going to give Resident A anything for pain because he could not have a bowel movement. During an interview and record review of the Grievance/Complaint Report, Record of Complaint, and Witness Statements on 1/29/25 at 9:28 AM, the Social Services/Grievance Official agreed that Resident A's complaint constituted an allegation of abuse and neglect. In an interview with the DON on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, she was reviewing nursing notes and found documentation by LPN #3 that Resident A had yelled that he had requested pain medication over an hour ago. The DON further stated that, while in the Assistant Director of Nursing's (ADON) office, the resident's son reported that the previous evening, the resident had requested pain medication, but the nurse told him he did not need it due to stomach issues. The DON later spoke with the resident in the therapy department, where he confirmed he had not received his pain medication the previous night and expressed fear of LPN #3 due to her loud and rude behavior. The DON stated that during her investigation, she received reports from LPN #2 that LPN #3 had been loud and cursing in the hallway. When she interviewed LPN #3, the nurse admitted to withholding the pain medication because the resident was constipated. The DON informed her that this was not a valid reason to deny medication. The nurse was subsequently terminated. However, the DON stated she could not substantiate the allegations that staff had taken or ignored the resident's call light and that after review of the camera footage at that time you could see a CNA going in and answering his call light that night. The DON agreed that this incident was an allegation of abuse and neglect. In an interview at 10:12 AM on 1/29/25 with the Administrator he confirmed that the Grievance Investigation was an allegation of abuse. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. A record review of the Admission Record revealed that Resident A was admitted to the facility on [DATE] with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.

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NAME OF PROVIDER OR SUPPLIER: MS Care Center of Alcorn County, Inc-Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 3701 Joanne Drive Corinth, MS 38834	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on record reviews and staff interviews the facility failed to identify and report an allegation of abuse and neglect to the proper authorities within prescribed timeframes as required for one (1) of 20 residents reviewed. Resident A. Cross reference F600, F656, F697 Findings Included: Review of facility policy Freedom from Abuse, Neglect and Exploitation revised October 2022 revealed Policy Statement: Practices of omitting part of resident care or neglecting resident and misappropriation of property is to be considered as leading to abuse and should be investigated and treated as abuse .5. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse .are reported immediately to the supervisor, and the administrator of the facility, or other officials, such as the State Board of Health and the Office of the Attorney General . A review of the Record of Complaint documented by the Director of Nursing (DON) on 10/21/24 indicated that Resident A's responsible party (RP) stated that the night shift nurse was rude and hateful. The resident expressed a desire to discharge home, stating he felt unsafe and was not receiving proper care at night. The investigation found that the resident's pain was left untreated, and staff interviews revealed examples of misconduct toward resident. The immediate actions included the termination of the night shift nurse, relocating the resident to a different hall per his request, and in-servicing staff on professional conduct, abuse, and neglect. A record review of the Grievance/Complaint Report documented by Social Services on 10/22/24 revealed that Resident A reported staff was rude to him and refused to give him his medications, stating it was bad for him and that he did not need it. He further reported that staff threw his call light on the floor, refused to assist him onto the bedside commode, and that he was scared. Record review of the Witness Statement documented by the Physical Therapy Assistant (PTA) on 10/21/24 revealed that Resident A stated he wanted to leave the facility. The resident became emotional and expressed fear, stating he had no defense and could not protect himself. He also reported that no one answered his call light, that staff threw it on the floor, and when he asked for it back, they refused, telling him he did not need it. Record review of a Witness Statement documented by Licensed Practical Nurse (LPN) #2 on 10/22/24 revealed that she heard LPN #3 yelling, Shut up! down the hall on 10/19/24 while Resident A was calling for help. She also stated that LPN #3 said she was not going to give Resident A anything for pain because he could not have a bowel movement. On 1/29/25 at 9:28 AM, during an interview with the Social Services/Grievance Official, she agreed that Resident A's complaint constituted an allegation of abuse and neglect and confirmed that it had not been reported to the State Agency. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	At 10:10 AM on 1/29/25, the DON confirmed that this incident was an allegation of abuse and acknowledged that it had not been reported to the State Agency because she had not identified it as such at the time. At 10:12 AM on 1/29/25, the Administrator confirmed that it constituted an allegation of abuse and neglect and should have been reported to the State Agency and stated that he typically reports all such allegations but did not recall being aware of this specific incident. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. A record review of the Admission Record revealed that Resident A was admitted to the facility on [DATE] with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on record review, staff interview and facility policy review, the facility failed to implement pain management care plan interventions and failed to develop a care plan with individualized interventions to include triggers for Post Traumatic Stress Disorder (PTSD) for two (2) of 20 sampled resident care plans reviewed. Resident A and Resident #64. Findings include: Record review of the facility policy Pain Management revealed, Policy: The facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. A record review of Resident A's Care Plan revealed, Focus: Risk for altered comfort related to benign hypertrophy of the prostate (BHP) and pain related to fractures, with interventions including: .Administer pain medication as needed . A record review of the Grievance/Complaint Report documented by Social Services/Grievance Official on 10/22/24 revealed that Resident A reported staff refused to administer his pain medication. The investigation findings noted: Resident pain left unattended. A record review of Progress Notes for Resident A, dated 10/21/24 at 1:39 AM, revealed that the resident yelled out, stating, I asked for my medicine an hour ago. Do you just not have any help? A record review of the Medication Administration Record (MAR) revealed that Resident A had an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams), with instructions to administer one (1) tablet orally every six (6) hours as needed for pain. Further review of the MAR revealed that on 10/20/24, Resident A received a dose of pain medication at 1:34 PM. However, there was no documentation that the resident received any additional pain medication until 9:58 AM on 10/21/24. In an interview with the Director of Nursing (DON) on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, Resident A's son voiced concerns that the nurse did not give his father any pain medication last night. The DON stated that she interviewed Licensed Practical Nurse (LPN) #3 regarding not administering pain medications to the resident and the nurse stated that she withheld the pain medication because the resident was constipated. On 1/30/25 at 9:41 AM, during an interview with the Minimum Data Set (MDS) Coordinator and the MDS LPN, they stated that the purpose of the care plan is to guide staff in providing appropriate care for the resident. The MDS Nurses confirmed that the nurse failed to follow the care plan when she did not administer pain medication as needed and that were requested by the resident. They further explained that the potential negative outcomes of untreated pain include unrelieved pain, increased anxiety, and difficulty participating in therapy and Activities of Daily Living (ADLs). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. The Pain Assessment Interview in section J documented that Resident A had experienced occasional pain over the past five (5) days, which limited his daily activities. He rated his pain as a five (5) on a numeric scale from zero (0) to ten (10), with zero (0) representing no pain and ten (10) representing the worst pain imaginable. A record review of the Admission Record revealed that Resident A was admitted to the facility on [DATE] with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24. Resident #64 Record review of facility policy titled, Trauma-Informed Care undated, revealed, The general idea of trauma-informed care is to provide increased sensitivity to residents who have experienced trauma. Educating staff on how to interact with residents in an effort to limit triggering events and provide sensitive psychosocial interventions. A Care Plan for a resident who has experienced requires the same structure as all resident care plans - there is an identified problem, a goal and interventions. The problems must be measurable and time-based. Broad generalizations are insufficient. Goal: . Resident will describe any triggers or stresses related to traumatic events and how they cope with it. The policy also revealed, Person centered care plan is the key to Trauma Informed Care, Resident Centered Care mandates include: address training needs of staff to improve knowledge and sensitivity; identify an individual's hope, capacities, interests, preferences, needs, and abilities; the individual is the expert of his/her life; practice is a collaborative process; individual choice is evident; resident's voice is used in treatment plans - goals are in his/her own words; strength based, recovery-oriented principles; assess for traumatic histories and symptoms; recognition of culture and practices that are re-traumatizing. Record review of Resident #64's Care Plan, date initiated 10/10/24, revealed, Focus: Psychiatric diagnosis related to post traumatic stress disorder, but the care plan did not include specific triggers that the resident experienced due to his diagnosis. During an interview on 1/28/25 at 11:55 AM, Resident #64 revealed he was in the Vietnam War, and he suffered from Post Traumatic Stress Disorder (PTSD) from his military service. He stated he was left for dead and the two soldiers with him were killed and it was a miracle he survived. He said that during that event, he was praying for God to keep him still so they would think he was dead and then he talked about how his mother prayed constantly for him to safely return home. He believed that God gave him the strength not to move even though he was getting kicked and beaten. He acknowledged he had triggers such as loud thunder or a loud noise from something being dropped, and when he heard these things, I almost hit the floor. While he was talking about his experience, he became teary eyed and cried softly. During an interview on 1/29/25 at 4:15 PM, the Director of Nursing (DON) revealed the resident had a diagnosis of PTSD and a care plan was developed for this. She stated a care plan should guide staff in the individualized care of each resident. She confirmed a PTSD assessment was not done, and triggers were not identified, therefore, the care plan did not give staff information needed for the triggers that affected this resident's mental health status. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	An interview with Registered Nurse (RN) MDS Coordinator on 1/30/25 at 9:30 AM, revealed she was responsible for developing and updating care plans to provide the staff with a guide for the resident's care. She stated that since the resident was not assessed for his PTSD needs and triggers, the care plan did not contain these items. She stated for a resident with PTSD, the staff should be aware of triggers that could cause the resident to have increased anxiety and they needed to be included in the care plan. She confirmed the facility failed to individualize a care plan by including triggers for a resident with PTSD. Record review of Resident #64's Admission Record revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD. Record review of the MDS Section C dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #64 was cognitively intact. Record review of Resident #64's admission MDS Section I dated 7/21/22 and the most recent quarterly assessment dated [DATE] revealed a diagnosis of PTSD.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on record reviews, staff interviews, and facility policy reviews, the facility failed to ensure that a resident received pain medication as ordered by the physician for one (1) of one (1) resident reviewed for pain management. Resident A. Cross reference F600, F656, F609 Findings include: Record review of the facility policy Pain Management dated September 2022 revealed, Policy: The facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. A record review of the Admission Record revealed that Resident A was admitted to the facility on [DATE] with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24. A record review of the Grievance/Complaint Report documented by Social Services/Grievance Official on 10/22/24 revealed that Resident A reported staff refused to administer his pain medication. The investigation findings noted, resident pain left unattended. A record review of Progress Notes for Resident A, dated 10/21/24 at 1:39 AM, revealed that the resident yelled out, stating, I asked for my medicine an hour ago. Do you just not have any help? A record review of the Medication Administration Record (MAR) revealed that Resident A had an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams), with instructions to administer one (1) tablet orally every six (6) hours as needed for pain. Further review of the MAR revealed that on 10/20/24, Resident A received a dose of pain medication at 1:34 PM. However, there was no documentation that the resident received any additional pain medication until 9:58 AM on 10/21/24. Record review of the Pain Assessment Interview dated 10/01/24 in Section J documented that Resident A had experienced occasional pain over the past five (5) days, which limited his daily activities. He rated his pain as a five (5) on a numeric scale from zero (0) to 10, with zero (0) representing no pain and 10 representing the worst pain imaginable. A record review of a Witness Statement dated 10/22/24 revealed that Licensed Practical Nurse (LPN) #2 reported hearing LPN #3 state that she was not giving Resident A pain medication because he could not have a bowel movement. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 1/29/25 at 10:05 AM, an interview with the Director of Nursing (DON) she stated that when she arrived at work on 10/21/24, she was reviewing nursing notes and saw the documentation by LPN #3 regarding Resident A's request for medication. While reviewing this information, Resident A's son approached her and reported that his father had requested pain medication the previous evening, but the nurse told him he did not need it due to stomach issues. Later, in the therapy department, Resident A confirmed to the DON that he had not received his pain medication the previous night. Upon interviewing LPN #3 regarding not administering requested pain medication, the nurse stated that she withheld the pain medication because the resident was constipated. The DON stated that she informed the nurse that this was not a valid reason to withhold pain medication, and that the medication should have been administered as ordered by the physician. The DON agreed that the resident's pain was left untreated throughout that night. During an interview with the Minimum Data Set (MDS) Coordinator on 1/30/25 at 9:41 AM, she stated that failure to administer pain medication as prescribed could lead to unrelieved pain, anxiety, and difficulty participating in therapy and Activities of Daily Living (ADLs). A record review of the MDS with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact.