

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/17/2025
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	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</b></p> <p>Based on staff and resident representative (RR) interviews, record review, and facility policy review, the facility failed to notify the resident representative of a significant change in physical condition and that the resident was being sent to the hospital for one of three residents reviewed. Resident #1.</p> <p>Findings Include:</p> <p>Review of the undated facility policy Required Notices revealed under Notification of changes: Facility will immediately inform the resident; consult with resident's physician; notify, consistent with their authority, the resident representative when: .b. The resident has a significant change in their physical, mental, or psychosocial status in either life threatening conditions or clinical complications d. A decision to transfer or discharge the resident from the facility .</p> <p>A phone interview on 03/17/25 at 9:06 AM with Resident #1's RR revealed that she was upset about a recent situation that occurred at the facility. RR revealed that she gone into the facility on [DATE], walked into Resident #1's room and found that her bed was stripped, and she was not there. She revealed that she went to the nurses' station and the staff told her that Resident #1 was in the hospital and had been there since 03/08/25. RR revealed that she had not been notified of a change in condition or of the transfer to the hospital and this was not acceptable.</p> <p>An interview on 03/17/25 at 9:42 AM with the Director of Nursing (DON), revealed that Resident #1's RR came into the facility on [DATE], found that Resident #1 was in the hospital and complained about not being notified about her change in condition or the transfer to the hospital that happened over the weekend. DON revealed that she came in on Monday morning, 03/10/25, ran a report and found out that Resident #1 had been sent out to the hospital on 03/08/25 for low oxygen levels. DON revealed that she looked into the situation and found that Licensed Practical Nurse (LPN) #2 was taking care of Resident #1 on the night shift of 03/07/25. DON revealed that LPN #2 asked LPN #1 for help to get the paperwork ready for ambulance transfer when she found that Resident #1 was having trouble breathing. DON revealed that after interviewing the two nurses, she found that LPN #1 thought LPN #2 had called the RR and that LPN #2 thought LPN #1 called her and due to miscommunication, they failed to notify the RR that the resident had been sent to the hospital and was admitted . DON confirmed that the nurse was supposed to notify the RR with any resident change in condition or transfer to the hospital and this was not done.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/17/2025
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	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview on 03/17/25 at 9:45 AM with LPN #1 revealed that he worked on the 11 PM - 7 AM night shift on 03/07/25 and that Resident #1's oxygen dropped too low on the morning of 03/08/25 and LPN #2 asked him to come and help with the situation. He revealed that they checked Resident #1's vital signs and found that her oxygen level was very low, reported it to the doctor and he ordered her to be sent to the hospital. LPN #1 revealed that LPN #2 asked him to print the necessary paperwork off the computer to be sent to the hospital with Resident #1. He revealed that he did not contact Resident #1's RR, that he assumed that the other nurse had since Resident #1 was her assigned patient. LPN #1 revealed that when they send a resident out to the hospital, they were supposed to always call the resident's RR and let them know. He also revealed that had he known that LPN #2 did not call the RR, he would have done it.</p> <p>A phone interview on 03/17/25 at 12:55 PM with LPN #2, revealed that she was working on the medication cart on the night shift, 11 PM - 7 AM, of 03/07/25. She revealed that she was preparing Resident #1's medications around 5:30 AM on the morning of 03/08/25, when an aide came to her and reported that Resident #1 was having trouble breathing. LPN #2 revealed that she went in and checked on her and found that her heart rate was elevated, and her oxygen saturation was extremely low, down in the 30's. She revealed that she called the doctor and received an order to send Resident #1 out to the emergency room . LPN #2 revealed that LPN #1 came to help, and she asked him to print out all the necessary paperwork for the transfer. She revealed that while he did that, she called 911 and then called the ER (emergency room ) and gave them a report. LPN #2 revealed that LPN #1 printed the paperwork, and she stated, I just assumed he did everything else. She revealed that she was in the middle of the medication pass, there was a lot going on, and she thought LPN #1 had called the RR and he assumed she had. LPN #2 revealed that she should not have assumed that LPN #1 called the Resident #1's RR, she should have checked with LPN #1 and made sure it was handled. LPN #2 revealed that she realized that because she failed to notify the RR, Resident #1 went out to the hospital without any family knowing her condition, and this should not have happened. LPN #2 confirmed that they were supposed to inform the RR of any changes in a resident's condition and supposed to notify the RR if a resident had to transfer to the hospital.</p> <p>Record review of Resident #1's Late Entry Progress Note with effective date of 03/08/25 at 05:50 revealed CNA (Certified Nursing Assistant) reported resident was not breathing correctly. went to check on resident and residents bipap trilogy was in use. resident was having difficulty breathing .MD (Medical Doctor) notified New orders to send resident to ER (emergency room ) for treatment. Dispatch notified. Report called to ER. Resident transported to ER via ambulance. Was able to get O2 (oxygen) up to 62%.</p> <p>Record review of the facility Change of Condition Report dated 03/08/25 revealed that Resident #1 was sent to the hospital at 5:50 AM for dyspnea.</p> <p>Record review of Grievance/Complaint Report dated 03/11/25, revealed that (proper name) Resident #1's RR wasn't notified about resident being sent to the hospital. Documentation on the form revealed Under Details: (proper name) states she wasn't notified when resident was sent to hospital. She found out when she came to visit resident on Monday, 3-10-25.</p> <p>Record review of Resident #1's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebrovascular Disease, Cerebral Infarction, and Acute Respiratory Failure with Hypoxia and Hypercapnia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/17/2025
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	
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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of Resident #1's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/22/25 revealed that a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely/never understood.		