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| 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 01/30/2025 |
| 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.

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>47874</p> <p>Based on resident and staff interviews, record review, and facility policy review, the facility failed to act upon and resolve resident grievances regarding cold food and lack of hot water for six (6) of eight (8) residents in the Resident Council meeting. Resident #5, Resident #13, Resident #28, Resident #43, Resident #64, and Resident #73</p> <p>Findings Include:</p> <p>Review of the facility policy titled Grievances undated, revealed under, . 2. The resident has the right and the facility will make prompt efforts to resolve grievances the resident has .</p> <p>Record review of the Resident Council Meeting Agenda dated 10/29/24 revealed Resident #73, Resident #43, and Resident #5 voiced concerns: Food is getting cold by the time it gets to us (Breakfast, Lunch, Supper).</p> <p>Record review of the Resident Council Meeting Agenda dated 11/26/24 revealed, Resident #43 voiced a complaint of bacon being cold. Resident #64 voiced, The food is cold because staff doesn't start passing trays until about 10-15 minutes after trays are on the hall. Also revealed under, Dietary . talked with staff about serving hot food.</p> <p>Record review of the Resident Council Meeting Agenda dated 12/31/24 revealed, under, Dietary: . talked with cook about cold food.</p> <p>Record review of the Record of Complaint for Resident #73 dated 1/15/25 revealed under, Nature of Complaint: Says gravy is always cold, eggs are cold .</p> <p>Record review of the Grievance/Complaint Report for Resident #43 dated 1/20/25 revealed under, Grievance/Complaint . food cold on 1/17/25 at lunch. Also revealed under, Details: Friday in dining room at lunch - trays came out and it was about 10 minutes before staff came to pass trays and my fries were cold.</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 |
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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 255110 | If continuation sheet Page 1 of 14 |

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a Resident Council meeting held on 1/28/25 at 4:00 PM, Resident's #13, #28, #43, #64, and #73 revealed, cold food had been a problem for a while, and it had been discussed in the Resident Council meetings. Resident #13 voiced at lunch that her chicken pot pie was cold. She revealed that she got the dietary department to come down to her room and asked for it to be heated. Resident #28 revealed, he ate in the dining room at lunch and his soup was cold. Residents #5, #13, #43, #64, and #73 revealed they had been getting cold food at times for breakfast, lunch, and supper. All residents agreed they get cold food commonly when they eat in their room but agreed it does happen in the dining room. Resident #5 (the Resident Council President) revealed he was not aware of anything the facility had done to address the cold food. Resident #43, #64, and #73 voiced once the kitchen brings the meal carts out, it normally takes 10-15 minutes before anyone touches the trays to begin passing them out to the residents.</p> <p>An interview with Social Services #1 on 1/29/25 at 10:00 AM revealed she attends the Resident Council meetings every month. She confirmed the residents had been complaining about cold food, but she thought the issue had gotten better. SS #1 revealed she writes up the things discussed in the meetings and afterward she distributes the concerns to whoever was over the department, and they were to handle it. She revealed if there was a dietary concern, such as cold food, it would have been given to the Dietary Manager to handle. She revealed the Dietary Manager had started overhead paging to notify the staff when the meal trays were out and ready to be served. SS #1 acknowledged cold food was a topic trend in the past couple of Resident Council meetings and confirmed the issue with cold food was an unresolved grievance.</p> <p>An interview with the Dietary Manger (DM) on 1/29/25 at 10:18 AM confirmed she was aware of the concerns coming from the Resident Council meetings related to cold food. She revealed she had talked to the dietary staff and explained to them, they needed to cut the hot box on sooner, so the plates would get warm. The DM revealed she had also started announcing when the meal trays were ready, so there would not be a delay in pass time.</p> <p>An interview with the Administrator (ADM) on 1/29/25 at 2:00 PM revealed he was not aware of any resident concerns related to cold food. He revealed they did have trouble at one point in the past with cold food, but that had gotten better. The ADM confirmed resident grievances should be acted upon promptly and resolved. He stated, Nobody wants cold food.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #5 on 5/21/12.</p> <p>Record review of the Brief Interview for Mental Status (BIMS) Evaluation dated 12/20/24 revealed a BIMS summary score of 12, indicating Resident #5 was moderately cognitively impaired.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #13 on 7/26/24.</p> <p>Record review of the BIMS dated 1/10/25 revealed a BIMS summary score of 14, indicating Resident #13 was cognitively intact.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #28 on 3/29/24.</p> <p>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/24 revealed a BIMS summary score of 15, indicating Resident #28 was cognitively intact.</p> <p>(continued on next page)</p> | | |

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of the Admission Record revealed the facility admitted Resident #43 on 9/09/19.</p> <p>Record review of the BIMS dated 1/17/25 revealed a score of 15, indicating Resident #43 was cognitively intact.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #64 on 7/15/22.</p> <p>Record review of the BIMS dated 1/07/25 revealed a score of 15, indicating Resident #64 was cognitively intact.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #73 on 4/04/23.</p> <p>Record review of the BIMS dated 1/01/25 revealed a score of 15, indicating Resident #73 was cognitively intact.</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure a home-like environment, as evidenced by cold water temperatures in the 300-hall shower room for one (1) of two (2) shower rooms observed.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Resident Rights undated revealed, 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 .</p> <p>During an interview on 1/28/25 at 10:15 AM, Resident #28 revealed that the shower room on the 300 hall where we take our showers is often without hot water. He revealed that it was a big problem last week, and when my aide brought me back to my room after the cold shower, I saw the Administrator in the hallway and told him about the issue.</p> <p>An interview on 1/29/25 at 9:50 AM, Certified Nurse Aide (CNA) #1 revealed she has had several residents complain of the water being cold in the 300-hall shower room. She revealed last week that she took Resident #28 to the 300-hall shower room for his shower, turned the water on, and waited for about a minute; it got a little warm but not warm enough for a shower. She stated, I kept apologizing to (Resident #28), I felt so bad for him. When I was taking (Resident #28) back to his room, we saw the Administrator in the hallway, and (Resident #28) told him about the water being cold. She revealed that she had reported the issue to the unit manager before, and maintenance would test the water in the shower room, and they would say that it was ok. She revealed that the water still does not get warm enough.</p> <p>During an interview on 1/29/25 at 9:55 AM, CNA #2 revealed that multiple residents complained of the cold water in the 300-hall shower room. She revealed that she had not reported it to anyone because maintenance was already aware of the issue.</p> <p>In an interview on 1/29/25 at 11:10 AM, Resident #28 revealed he got a bed bath today. He also revealed that CNA #1 was assigned to him today and she told him that the water was cold in the shower and that it would be better for me to have a bed bath, so I did that.</p> <p>During an interview on 1/29/25 at 11:20 AM, CNA #3 revealed that residents have been complaining of the 300-hall shower room water being cold, and she revealed that she had reported it to maintenance in the past.</p> <p>In an interview on 1/29/25 at 11:30 AM, Maintenance worker #1 revealed that he is aware of complaints about the cold water in the shower room on 300 Hall. He revealed that he checked the water this morning, which was 105 degrees.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview and observation on 1/29/25 at 11:45 AM, Maintenance worker #2 revealed he checks the water temperatures two times daily and does it at random rooms. The water temperature is always running between 105-110. He revealed that he didn't understand how the water temperature in the 300-hall shower room was running colder. Maintenance worker #2 offered to check the water temperature in the shower room and stated, We can check it in the shower room sink since they are on the same water line. The State Agent (SA) encouraged the Maintenance worker to check the water from the middle shower stall, where the staff gave the residents their showers instead. Maintenance worker #1 tested the water temperature with a digital thermometer and after two minutes of running the water, an observation of the digital thermometer temperature gauge revealed that the water temperature was 88 degrees. Maintenance workers #1 and #2 confirmed the water was too cold for a shower and revealed they needed to fix this. An observation of the water temperature in the shower room sink revealed the hot water temperature at 106 degrees. Maintenance workers #1 and #2 revealed they always checked the sink in the 300-shower room and didn't check the water from the shower faucet because they felt like the water in the sink gave a more accurate reading, which was always around 105 degrees.</p> <p>During an interview on 1/29/25 at 2:00 PM, the Administrator revealed he wasn't aware of an issue with the cold water until his maintenance department notified him today. He revealed he did recall talking with Resident #28 last week in the hallway but did not recall the context of his conversation. He confirmed that there was obviously a problem with the valves in that shower stall. He confirmed this is the resident's home, and we were not promoting a homelike environment by not ensuring the residents get a warm shower.</p> <p>A record review of Resident #28's Admission Record revealed the resident was admitted to the facility on [DATE].</p> <p>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/24 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p> | | |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878</p> <p>Based on staff interviews, record review, and facility policy review, the facility failed to submit a status change for a resident with a new mental illness diagnosis to the Preadmission Screening and Resident Review (PASRR) program for one (1) of four (4) residents reviewed. Resident #41</p> <p>Findings include:</p> <p>Record review of facility letterhead revealed, Admissions Coordinator uses the Division of Medicaid Pre-Admission Screening (PAS) Instruction Manual to determine the admission PAS process. Social Services uses the Maximus guide to determine status change or potential status change that require submission of a Resident Review status change in MS (Mississippi).</p> <p>Record review of guidelines titled, Mississippi PASRR Identifying Status Changes, dated 8/3/22, revealed, The nursing facility (NF) must submit a Status Change (SC) to Maximus using the Level I PASRR Resident Review process whenever a Significant Change in Condition occurs for an individual with a PASRR identified condition (i.e., Serious Mental Illness (SMI), Intellectual and/or Developmental Disability (ID/DD), and/or Related Condition (RC). The MS division of Medicaid Administrative Code also defines a Significant Change as being applicable to persons with newly discovered or suspected MI, ID/DD, and/or RC.</p> <p>During an interview on 1/29/25 at 2:00 PM, Social Service #1 revealed it was her responsibility to submit the Status Change into the PASRR system for any resident with a new serious mental illness diagnosis. The resident was admitted to the facility on [DATE] and had the PAS dated 8/23/23 and did not require a Level II at that time. On 1/29/24, Resident #41 had a new diagnosis of Schizoaffective Disorder, which required a status change to be submitted, but that was not done. She confirmed she was not notified of the diagnosis and therefore, did not submit as required.</p> <p>An interview with the Director of Nursing (DON) on 1/29/25 at 2:15 PM, revealed it was important to accurately follow the PASRR process to ensure each resident was properly placed and received needed services. She confirmed the facility failed to submit a PASRR status change for a resident with a new mental health diagnosis of Schizoaffective Disorder.</p> <p>During an interview on 1/29/25 at 2:55 PM, the Administrator confirmed the facility failed to submit a PASRR change of status for Resident #41's new diagnosis of Schizoaffective Disorder.</p> <p>Record review of Resident #41's Preadmission Screen (PAS) dated 8/23/23, revealed the resident did not have a diagnosis of a serious mental illness and was determined that, level of care automatically approved due to recommended outcome from submitted assessment.</p> <p>Record review of Resident #41's Admission Record revealed the resident was admitted to the facility originally on 10/19/17 with the most recent admission being 8/23/23. Diagnosis included Schizoaffective Disorder with an onset date of 1/29/24 and Cerebral Infarction with an onset date of 10/19/17.</p> <p>(continued on next page)</p> | | |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #41's Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 11/23/24 revealed a Brief Interview for Mental Status (BIMS) was unable to be obtained and noted as resident is rarely/never understood Section I Active Diagnoses item I6000 revealed Schizophrenia was coded yes.</p> |

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| <p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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 .</p> <p>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.</p> <p>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?</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>Resident #64</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>Record review of Resident #64's Admission Record revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD.</p> <p>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.</p> <p>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.</p> |

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| 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 01/30/2025 |
| 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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878</p> <p>Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide trauma care and services for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one (1) of 20 sampled residents. Resident #64</p> <p>Findings include:</p> <p>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.</p> <p>On 1/28/25 at 11:55 AM, an interview with Resident #64 revealed he was in the Vietnam War and he suffered from 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 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.</p> <p>Interviews with Social Service #1 on 1/29/25 at 2:00 PM and 3:10 PM, revealed on admission, each resident or resident's family filled out a Cultural Assessment packet and if any of the events in this assessment had been experienced by the resident, they addressed that specific area for the resident's care. She acknowledged this packet was started in 2023 after Resident #64's admission to the facility in 2022, therefore, this evaluation for trauma care needs was not done on his admission. She confirmed that when the facility began the assessments, the staff failed to assess resident for trauma, triggers, interventions, and appropriate treatment for his mental health care needs. She also confirmed this resident was not followed by the facility's mental health care provider to receive specialized mental health care services during his time at the facility, even though he had a PTSD diagnosis.</p> <p>An interview on 1/29/25 at 4:15 PM, the Director of Nursing (DON) revealed Resident #64 was admitted to facility in 2022 with a diagnosis of PTSD, but did not have a trauma assessment done or triggers identified, and he had not received mental health services from the facility's mental health care specialist. She acknowledged that PTSD should be assessed and triggers that interfere with quality of life should be identified in order to provide each resident with care to attain their highest possible mental health status. She confirmed the facility failed to adequately assess the resident for his diagnosis of PTSD, determine triggers, and provide mental health services.</p> <p>During an interview on 1/29/25 at 4:25 PM, the Administrator confirmed that any resident with PTSD should be evaluated for appropriate mental health care services and confirmed the facility failed to provide this for a resident with a PTSD diagnosis.</p> <p>(continued on next page)</p> | | |

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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 | |

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

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| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #64's Admission Record revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD.</p> <p>Record review of Resident #64's Minimum Data Set (MDS) Section C dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p> <p>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.</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure food temperatures were completed and documented adequately for one (1) of three (3) kitchen observations.</p> <p>Findings include:</p> <p>A review of the facility policy titled Kitchen Thermometers undated revealed, A food thermometer should also be used to ensure that cooked food is held at safe temperatures until served. Cold foods should be held at 40 degrees F (Fahrenheit) or below. Hot food should be kept hot at 140 degrees F or above . Temperature Recording Preserves the Food's Quality. If facilities don't keep food at the proper temperature, its quality can quickly deteriorate .</p> <p>During the initial tour of the facility with resident interviews on 1/28/25 at 10:10 AM, Resident #28 revealed, I have received cold chicken soup on more than one occasion. Last week, I requested two bowls of soup; they brought it, but it was cold.</p> <p>During dining room observation on 1/28/25 at 11:50 AM, Resident #28 was overheard telling a staff member that his soup was cold. The soup was returned to the kitchen, and Dietary Worker #1 confirmed the food item was chicken noodle soup. She checked the temperature of the chicken soup and revealed the temperature was a little under 80 degrees, and she wasn't sure what the temperature for the soup was supposed to be. The Dietary Manager checked the soup temperature and revealed it was 80 degrees when it was supposed to be at least 135 degrees. Dietary workers #2 and #3 confirmed the soup temperature was not checked today.</p> <p>In an interview on 1/28/25 at 12:40 PM, Dietary worker #3 revealed she cooked breakfast and lunch meals today and did not check food temperatures for either meal. She revealed that her initials with the temperatures were on the Prepared Food Record; however, she had not checked the temperatures or initialed the sheet. She stated, I think (Dietary worker #1) filled that sheet out. She confirmed she was supposed to check the temperature of the food items on the steam table but just didn't.</p> <p>A record review and observation on 01/28/25 at 12:30 PM revealed a document titled Prepared Food Temperature Record dated January 2025 revealed that all food temperatures were documented for all three meals for the 28th of January with staff member initials under the date of the 28th.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>In an interview on 1/28/25 at 12:45 PM, the Dietary Manager confirmed the temperatures on the Prepared Food Temperature Record were already documented for today despite the temperatures not being taken. She revealed that the temperature record was already filled out for the upcoming dinner meal, which hadn't even happened yet. She stated, I don't watch my dietary workers take the food temperatures; I trust them to do their jobs correctly, and the way it looks, they are not doing what they should have been. She revealed that it is very important that temperature checks are done for each food item that is put on that steam table and served to the residents. She revealed that a resident could get a foodborne illness by not ensuring all food temperatures are within the normal range. She revealed this is just not acceptable and the dietary workers should ensure the food temps are being done. She confirmed the soup was cold and that, according to her staff admission, they had not checked the temperature of the soup before sending it out to the resident.</p> <p>In an interview on 1/28/25 at 1:00 PM, Dietary worker #1 confirmed that she had recorded the temperatures but did not check any food items for breakfast or lunch and had already documented the temperatures for the dinner meal for that evening on the log. She confirmed that what she did was false documenting. She stated, I filled out the sheet because if I didn't do it, it wouldn't get done.</p> <p>During an interview on 1/29/25 at 2:07 PM, the Administrator revealed he felt the food quality was improving and had not heard any complaints about the food being cold. He revealed it is of the utmost importance that the temperature of the food is checked before serving it to our residents, which ensures good quality of the food being served and ensures no potential food-borne illness. He revealed he was unaware that the dietary staff did not check the food temperatures yesterday, which is unacceptable.</p> <p>A record review of Resident #28's Admission Record revealed the resident was admitted to the facility on [DATE].</p> <p>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/2024 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p> |