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	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, 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 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 #3Findings 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 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 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 (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 0686 Level of Harm - Actual harm Residents Affected - Few	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.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility failed to obtain informed consent from the resident or resident representative prior to initiating psychotropic medications for five (5) of 5 residents reviewed for unnecessary medications. Resident #4, Resident #6, Resident #10, Resident #12 and Resident #92 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 [DATE] 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 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 [DATE] 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 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 [DATE] 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), 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 [DATE] 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 [DATE] with medical diagnoses that included Major Depressive Disorder, Unspecified Dementia (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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.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.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 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 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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the resident's right to dignity was maintained by not providing privacy for a urinary catheter drainage bag for one (1) of six (6) residents with an indwelling catheter. Resident #3.Findings Include: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 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.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure resident privacy during wound care when privacy measures were not implemented for one (1) of four (4) care opportunities observed. Resident #90 Findings Include: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 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.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, staff interviews, 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 - 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure physician-ordered settings and proper oxygen integration for a Trilogy ventilator for one (1) of two (2) resident reviewed for respiratory care. Resident #100Findings 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.On 3/30/2026 at 9:59 AM, during an observation of Resident #100, he 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 three (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.On 3/31/26 at 8:02 AM, an observation 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 LPM (liters per minute) per NC (nasal cannula) every shift.During an interview with Licensed Practical Nurse (LPN) #2 on 3/31/26 at 10:36 AM, she 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.On 3/31/26 at 10:45 AM, an interview with LPN #4 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.During an interview with the Director of Nursing (DON) on 3/31/26 at 11:01 AM,, she 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.During a telephone interview with Proper name of medical equipment supplier Respiratory Therapist (RT) on 3/31/26 at 1:46 PM, she 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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.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.

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	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, 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: 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 [DATE], with medical diagnoses that included urinary tract infection and retention of urine. 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 (continued on next page)

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	04/01/2026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.