STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS Care Center of Morton	96 Old Highway 80 East Morton, MS 39117

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306 Based on interviews, record review, and facility policy review, the facility failed to ensure a medication was secured in a locked storage area and available to only authorized personnel when a medication was left at a resident's bedside for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility policy titled Administration and Documentation, revised July 24, 2015, revealed, . Under no circumstances is medication to be left at the bedside or given to the resident without him/her swallowing it in your presence, unless a physician has written an order to this effect and unless the facility has determined that the resident is mentally and physically capable of self-administration . On 12/4/24 at 12:00 PM, during an interview with Resident #1, he confirmed that in September 2024 of this year, his nurse left his new face cream at his bedside, and he used it all the time, hoping his face would heal faster. He confirmed that his daughter was upset because instead of healing faster, it irritated his face, and it had to be stopped. A record review of the dermatological consultation revealed the Visit Note, dated 9/4/24, revealed a local dermatologist, prescribed Fluorouracil 5% topical cream, to be applied two times a day on his scalp and down temples for two (2) weeks related to Actinic Keratosis. A record review of the Order Recap Report, with active orders for September, revealed an order for Fluorouracil External Cream 5% to be applied topically every shift related to Actinic Keratosis until 9/19/24, then discontinued. However, further review of the order revealed the Fluorouracil Cream was discontinued on 9/13/24 and a new order for Triamcinolone Lotion was ordered. The Triamcinolone Lotion was ordered to be applied BID (twice a day) for four (4) days on irritated places on the face, with a start date of 9/14/24 and an end date of 9/17/24. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with License Practical Nurse (LPN) #1 on 12/4/24 at 1:15 PM, she stated she had left the Fluorouracil External Cream 5 % at Resident #1's bedside. The resident was fussing about the cream, so she just left the cream in his room for a few days. LPN #1 stated that when she spoke to the resident's dermatologist, the dermatologist became upset when she learned the medication was at the resident's bedside. Following the incident, the nurse said the resident's physician discontinued the medication and prescribed a different cream because of his face being irritated. LPN #1 stated she reported the situation to the prior Director of Nurses (DON) before she resigned. On 12/4/24 at 1:30 PM, during an interview with DON, she revealed she began working at the facility on 8/31/24; during that time, the previous DON was present. The current DON confirmed that the facility must follow physician orders on medications, and they are not to be left at the bedside. On 12/4/24 at 2:30 PM, during an additional interview with the DON, she stated that after the incident related to Resident #1, the facility had a QAPI (Quality Assurance and Performance Improvement) meeting to discuss the incident. Following the meeting, there was Nurses' Meeting to plan additional in-services to reinforce the policy that medications and creams are not to be left at the bedside unless it is ordered. The in-services were mandatory for all nursing staff prior to returning to work. On 12/4/24 at 3:00 PM, during an interview with the Medical Provider, he confirmed that when he was made aware that Resident #1 had the prescribed Fluorouracil External Cream 5% topically at his bedside for approximately 9 days, and he observed the resident's face to be irritated. He stated that he discontinued the Fluorouracil External Cream and Triamcinolone lotion was ordered to be applied to the resident's face twice a day for 4 days. He stated that the facility should not leave any medication at the residents' bedside unless they are prescribed to be there. A record review of the Admission Record, revealed the facility admitted Resident #1 to the facility on [DATE]. The resident had diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia, Neoplasm of Uncertain Behavior of Skin, Actinic Keratosis, and Rosacea, Unspecified. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 11/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was moderately impaired. Validation: On 12/4/24, the State Agency (SA) validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when they were aware of the incident involving Resident #1. A review of the emergency QAPI meeting minutes revealed the facility held a QAPI meeting on 9/24/24 at 1:30 PM, in which the Infection Preventionist (IP) was present, and the Medical Director attended via phone. The SA verified through an interview with the DON and Administrator they attended the QAPI meeting to discuss the situation, and the facility policies related to not leaving medication at the bedside unless the facility has physician orders. The QAPI meeting concluded that Correction planned to in-service all nurses and interview all residents with Brief Interview of Mental Status (BIMS) over 12 to determine if any other residents experienced medications being left at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SA reviewed in-service sign-in sheets that began on 9/24/24 related to the administration of medications and reinforced the policy that stated, medication (pills or creams) are not to be left in a resident's room, unless the physician has written an order to this effect and the facility has determined that the resident in mentally and physically capable of self-administration. The DON conducted in-services in which they had every nurse sign the policies on medication administration.