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	12/23/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interviews, record review, facility policy review, and facility investigation review, the facility failed to protect the residents' right to be free from sexual abuse by another resident for two (2) of four (4) sampled residents. Resident #2 and Resident #3On 12/17/25 at 11:26 AM, Resident #1 (male) inappropriately touched the breast of Resident #2 (female) in the day room. After staff were notified, Resident #1 was taken to his room and left unsupervised. At approximately 11:32 AM, Resident #1 was assisted back to the day room by a staff member who was unaware of the incident. On 12/17/25 at 11:49 AM, Resident #1 inappropriately touched the breast of Resident #3 (female). The facility was aware prior to these incidents that Resident #1 had a history of sexually inappropriate behaviors, including sexual comments toward staff on 12/12/25, yet failed to implement immediate supervision or restrictions to protect other residents.The facility's failure to implement protective supervision resulted in Resident #2 and Resident #3 experiencing non-consensual sexual contact and placed other vulnerable female residents at risk for serious injury, serious harm, serious impairment, or death.This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 12/12/25, when Resident #1 made sexual comments toward facility staff. The State Agency (SA) notified the Administrator of the IJ and SQC on 12/23/25 at 9:30 AM and provided an IJ Template.Based on the facility's implementation of corrective actions on 12/19/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 12/20/25, prior to the SA's entrance on 12/22/25.Findings include:A review of the facility's policy, Freedom from Abuse, Neglect and Exploitation, dated September 2022, revealed, .F600 Free from Abuse and Neglect All residents of this facility will be free from abuse.The facility will take steps to ensure that the resident is protected from abuse.When a facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately.A review of the facility's policy, Identifying Sexual Abuse and Capacity to Consent, dated September 2022, revealed, .Policy Interpretation and Implementation 1. ‘Sexual abuse' is non-consensual sexual contact of any type with a resident.a. unwanted intimate touching of any kind especially of breasts or perineal area.Investigating an Allegation or Suspicion of Sexual Abuse 1. For any alleged violation or suspicion or sexual abuse, protective measures and an investigation.will begin immediately. These include: a. immediately implementing safeguards to prevent further potential abuse.A record review of the Facility Reported incident Initial Report dated 12/17/25, revealed an Allegation Type of Sexual Abuse. The initial report indicated that on 12/17/25 at 11:26 AM, Resident #1 inappropriately touched Resident #2 on her breast while in the Day Room. The event was witnessed by the facility's Janitor. The janitor separated the residents and notified Licensed Practical Nurse (LPN) #1, who took Resident #1 to his room and immediately went to the Director of Nursing (DON) office to notify her of the incident. While LPN #1 was walking to the DON's office, Resident #1 was attempting to come out of his room. Certified Nursing Assistant (CNA) #1, who had no knowledge of the incident and was not his assigned CNA, assisted him out of his room and back to the dayroom. At 11:49 AM, Resident #1 inappropriately touched Resident #3 on her breast. CNA #2 witnessed the incident and immediately separated the residents. The resident was immediately placed on one on one (1:1) observation. Resident #1A record review of the admission Record revealed the facility admitted Resident #1 on 4/26/2023 with current diagnoses including Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #1 had a Brief Interview for Mental Status score of 6, which indicated his cognition was severely impaired.A record review of the Progress Notes, dated 12/17/25, revealed, Nurse notified DON and Assistant Director of Nursing (ADON) of incident. While nurse was on the way to tell DON and ADON of incident, student CNA seen resident attempting to exit room, but notice wheelchair was stuck. Student CNA assisted resident out of the room due to no knowledge of the incident. While back in the day room resident inappropriately touch another female resident's breast. CNA immediately separated and took resident with her to notify nurse. ADON educated CNA and nurse that resident is to be on one on one observation. One on One observation was initiated immediately.A record review of the Behavior Reporting Form revealed that on 12/12/25 at approximately 12:00 PM in the facility's hallway, Resident #1 asked employee to see her breasts and documented that Resident stopped employee in the hallway and asked to see her breasts. Employee educated Resident on inappropriateness of request and instructed to not ask that. Resident showed understanding by nodding.A record review of the Psych Progress Note, dated 12/15/25 revealed Resident #1 had Presenting Symptoms

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interviews, record review, facility policy review, and facility investigation review, the facility failed to develop and implement a comprehensive care plan related to sexually inappropriate behaviors for one (1) of four (4) sampled residents. Resident #1On 12/17/25 at 11:26 AM, Resident #1 (male) inappropriately touched the breast of Resident #2 (female) in the day room. After staff were notified, Resident #1 was taken to his room and left unsupervised. At approximately 11:32 AM, Resident #1 was assisted back to the day room by a staff member who was unaware of the incident. On 12/17/25 at 11:49 AM, Resident #1 inappropriately touched the breast of Resident #3 (female). The facility was aware prior to these incidents that Resident #1 had a history of sexually inappropriate behaviors, including sexual comments toward staff on 12/12/25, yet failed to implement immediate supervision or restrictions to protect other residents.The facility's failure to develop and implement a comprehensive care plan resulted in Resident #2 and Resident #3 experiencing non-consensual sexual contact and placed other vulnerable female residents at risk for serious injury, serious harm, serious impairment, or death.This situation was determined to be an Immediate Jeopardy (IJ) which began on 12/12/25, when Resident #1 made sexual comments toward facility staff. The State Agency (SA) notified the Administrator of the IJ on 12/23/25 at 9:30 AM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/19/25, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 12/20/25, prior to the SA's entrance on 12/22/25. Findings include:A review of the facility's Develop/Implement Comprehensive Care Plan policy, dated September 2022, revealed, .The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs.1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required.A record review of the Facility Reported incident Initial Report dated 12/17/25, revealed an Allegation Type of Sexual Abuse. The initial report indicated that on 12/17/25 at 11:26 AM, Resident #1 inappropriately touched Resident #2 on her breast while in the Day Room. The event was witnessed by the facility's Janitor. The janitor separated the residents and notified Licensed Practical Nurse (LPN) #1, who took Resident #1 to his room and immediately went to the Director of Nursing (DON) office to notify her of the incident. While LPN #1 was walking to the DON's office, Resident #1 was attempting to come out of his room. Certified Nursing Assistant (CNA) #1, who had no knowledge of the incident and was not his assigned CNA, assisted him out of his room and back to the dayroom. At 11:49 AM, Resident #1 inappropriately touched Resident #3 on her breast. CNA #2 witnessed the incident and immediately separated the residents. The resident was immediately placed on one on one (1:1) observation.Resident #1A record review of the admission Record revealed the facility admitted Resident #1 on 4/26/2023 with current diagnoses including Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #1 had a Brief Interview for Mental Status score of 6, which indicated his cognition was severely impaired.A record review of the Care Plan Report for Resident #1 revealed a focus area titled Quality of Life, which included the statement, I see a mental health specialist. Further review revealed there were no individualized or specific care plan interventions, monitoring instructions, or staff guidance addressing Resident #1's documented sexually inappropriate behaviors.A record review of the Behavior Reporting Form revealed that on 12/12/25 at approximately 12:00 PM in the facility's hallway, Resident #1 asked employee to see her breasts and documented that Resident stopped employee in the hallway and asked to see her breasts. Employee educated Resident on inappropriateness of request and instructed to not ask that. Resident showed understanding by nodding.A record review of the Psych Progress Note, dated 12/15/25 revealed Resident #1 had Presenting Symptoms including Inappropriate Behavior. The Mental Stus Exam included .Comprehension: Difficulty with recall, unable to remember current events.Executive Function: Moderate impairment.impaired decision making.Judgement: Poor Ability to Plan, Poor Social Cognitions, Poor Memory.Thought Process: Confused/Slowed, slowed processing/intermittent confusion. The Case Conceptualization documentation included .He has some increased inappropriate behaviors (sexually impulsive). Discuss this with resident and he states, 'I only do that with people I'm comfortable with.' Discuss inappropriateness of behavior and resident v/u (verbalized understanding).Resident #2A record review of the admission Record revealed the facility admitted Resident #2 on 1/31/24 with diagnoses including Classical Phenylketonuria.A record review of the Comprehensive