

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER MS Care Center of Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>43283</p> <p>Based on observation, interviews, record review and facility policy review, the facility failed to honor residents' rights for self-determination by not allowing residents to go outside together for two (2) of 22 sampled residents. Residents #13 and #14.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Resident Rights Policy, revised 09/2022, revealed: .Facility will ensure that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The 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, recognizing each resident's individuality .</p> <p>Resident #13:</p> <p>A record review of Resident #13's Admission Record revealed the facility admitted the resident on 10/18/21. The resident had diagnoses that included Paranoid Schizophrenia and Neuroleptic Induced Parkinsonism.</p> <p>A record review of Resident #13's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/24/24 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 14, which indicated the resident was cognitively intact. Section F indicated that it is very important to Resident #13 to engage in his favorite activities and to go outside for fresh air when the weather is favorable. Section GG revealed no impairment in range of motion for upper or lower extremities and that Resident #13 is independent or requires supervision for Activities of Daily Living (ADLs).</p> <p>Resident #14:</p> <p>A record review of Resident #14's Admission Record revealed the facility admitted the resident on 09/20/21. The resident had diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis.</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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #14's Annual MDS with an ARD of 02/27/24 revealed a BIMS summary score of 15, which indicated the resident was cognitively intact. Section F indicated that it is very important to Resident #14 to engage in favorite activities and to go outside for fresh air when the weather is good.</p> <p>A record review of Resident #14's Quarterly MDS with an ARD of 08/13/24, Section GG, revealed that Resident #14 had no impairment in range of motion for upper or lower extremities, used a wheelchair, and was dependent on staff for transfers.</p> <p>During an observation and interview on 10/15/24 at 11:07 AM, Resident #13 and Resident #14 reported that they wished to go outside together, but were not allowed to do so because Resident #13 had previously tried to assist his wife, Resident #14. As a result, they were no longer permitted to be outside together alone. Resident #13 explained that he was trying to prevent his wife from falling. Resident #14 stated that while they could go outside for activities, they wished to be allowed outside at other times as well. She added that she attends dialysis three (3) times a week, and her husband, Resident #13, attends outpatient therapy three (3) times a week, meaning they are not together daily. Both residents reported that they have asked staff, both during the week and on weekends, to be allowed to go outside together but were consistently told that they could not. Both residents expressed that it is very important to them to spend time together outside and enjoy fresh air.</p> <p>During an observation on 10/16/24 at 9:20 AM, Resident #13 was not in his room, while Resident #14 was observed still in bed. Resident #13 explained that her husband was away for outpatient services and would return later that day.</p> <p>During an interview on 10/16/24 at 10:00 AM, Certified Nursing Aide (CNA) #2 in training explained that she had never seen Residents #13 and #14 go outside together. She had been working at the facility since August and had seen Resident #13 go outside by himself but had never seen the two together.</p> <p>During an interview on 10/16/24 at 11:04 AM, Licensed Practical Nurse (LPN) #4 stated that she was aware that Resident #13 and Resident #14 were not allowed to go outside together. She mentioned that she had been informed by staff that Resident #13 had previously attempted to assist Resident #14 when she almost fell, leading to the restriction.</p> <p>During an interview on 10/17/24 at 11:26 AM, Social Services #1 explained that she was unaware of the residents' complaints or that staff were not allowing Resident #13 and Resident #14 to go outside together. She recalled a past incident where Resident #13 tried to help his wife into a van but was not aware of staff preventing the couple from going outside by themselves. She mentioned that the facility employs agency staff and has different personnel on weekends, which might impact consistency. She emphasized that it is the residents' right to go outside when they choose, and she expects all staff to respect residents' rights at all times.</p> <p>During an interview on 10/17/24 at 12:05 PM, the Administrator stated that she was not aware that Resident #13 and Resident #14 were being prevented from going outside together. She emphasized her expectation that staff respect residents' rights at all times.</p> <p>During an interview on 10/17/24 at 2:00 PM, the Director of Nursing (DON) confirmed that she expects all staff to respect and honor residents' rights at all times.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680</p> <p>Based on interviews, record reviews, and facility policy review, the facility failed to ensure that a resident who did not have an advance directive received information or assistance in formulating an advance directive for one (1) of twenty-two (22) residents reviewed for advance directives. Resident #7.</p> <p>Findings Include:</p> <p>A record review of the Admission Record for Resident #7, revealed an admitted [DATE] with diagnoses including Dysphagia, Dementia, and Alzheimer's Disease.</p> <p>A record review of Resident #7's Admission Agreement Checklist dated 10/9/21, revealed that the resident does not have a Power of Attorney (POA) and that the checklist does not indicate acknowledgment of an Advance Directive.</p> <p>During an interview on 10/15/24 at 11:54 AM, Resident #7's Resident Representative (RR) stated that he has not established a Power of Attorney.</p> <p>During a record review of Resident #7's chart, there was no documentation acknowledging the existence of an Advance Directive or a Power of Attorney.</p> <p>During an interview on 10/16/24 at 1:50 PM, the Administrator stated that Resident #7 does not have an Advance Directive Acknowledgment Form or Power of Attorney. She mentioned that while they provided Resident #7's RR with a booklet on Advance Directives upon admission, there was no documentation indicating that the resident acknowledged receiving this information.</p> <p>During an interview on 10/16/24 at 2:10 PM, the Director of Nursing (DON) confirmed that Resident #7 does not have a Power of Attorney or a copy of the facility's Advance Directive Acknowledgment Form in her records.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680</p> <p>Based on record reviews, interviews, and facility policy review, the facility failed to complete a Minimum Data Set (MDS) discharge assessments accurately for one (1) of twenty-two (22) residents reviewed for assessments. Resident #109.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Resident Assessment Instrument (RAI) Policy (undated) revealed, It is the policy of the facility that the RAI will be done as follows: According to the guideline specified by: .Division of Medicaid .</p> <p>A record review of Resident #109's Face Sheet revealed an admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Hypertensive Chronic Kidney Disease, and Hypertensive Heart Disease with Heart Failure.</p> <p>A record review of Resident #109's Discharge MDS with an Assessment Reference Date (ARD) of 08/08/24 revealed that the discharge was coded as a short-term general hospital stay (acute hospital).</p> <p>A record review of Resident #109's Physician Order Sheet revealed a physician's order, written on 08/08/24 at 8:53 AM for Resident #109 to . (Name of home health) to follow up at home.</p> <p>A record review of the Departmental Notes dated 8/8/24 at 9:29 AM and signed by Social Services revealed MDS discharge assessment completed .on Thursday, August 8, 2024 .Resident left facility under the care of family .</p> <p>During an interview on 10/17/24 at 1:55 PM, the Registered Nurse/MDS Coordinator stated that the discharge should have been coded as the resident going home.</p> <p>During an interview on 10/17/24 at 2:08 PM, Licensed Practical Nurse (LPN) #3, an MDS nurse, stated that she had incorrectly coded the resident as being discharged to the hospital. She acknowledged that it should have been coded as a discharge to home and explained that she entered the information in error.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for 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>43283</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to implement a care plan intervention regarding changing oxygen (O2) tubing for one (1) of twenty-two (22) sampled residents. Resident #76.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Comprehensive Resident-Centered Care Plans (undated) revealed, . It is the policy of this facility to provide services based on the following requirements .Development/Implement Comprehensive Care Plan. The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment.</p> <p>A review of the facility ' s policy titled Oxygen Policy (undated) revealed, . It is the policy of this facility that oxygen will be utilized as follows: . with the specific physician orders . Date the tubing .</p> <p>A record review of the Comprehensive Care Plan with a start date of 3/22/23, revealed Resident #76 had a care plan intervention to Change my O2 tubing and wash filter every week on Friday.</p> <p>On 10/15/24 at 12:08 PM, during an observation, Resident #76 was observed receiving oxygen via nasal cannula at 2 liters per minute. The tubing was not dated to indicate the tubing had been changed. The resident reported that she must wear oxygen at all times.</p> <p>On 10/16/24 at 1:30 PM, during an observation and interview, Registered Nurse (RN) #4 observed and confirmed that Resident #76's oxygen tubing was not dated and stated the oxygen tubing should be changed weekly and dated.</p> <p>During an interview on 10/17/24 at 2:10 PM, the Minimum Data Set (MDS)/Care Plan Coordinator explained that the purpose of each resident's care plan is to inform staff about how to care for each resident. She emphasized that she expects all staff to follow a resident's care plan to ensure proper care.</p> <p>During an interview on 10/17/24 at 2:25 PM, the Director of Nursing (DON) stated that she expects all staff to follow the resident's care plan when providing care to any resident.</p> <p>A record review of the Admission Record revealed that the facility admitted Resident #76 on 01/18/23 with diagnoses including Chronic Diastolic (Congestive) Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24 revealed in Section O of the MDS that Resident #76 received oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50751</p> <p>A record review of the Medication Review Report dated 10/16/24 revealed Resident #76 a physician's order, dated 08/27/24, to change the oxygen tubing and wash the filter every week on Fridays.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>43283</p> <p>Based on observations, interviews, record reviews, and facility policy review, the facility failed to follow standards of practice for respiratory care regarding dating and changing oxygen tubing weekly and storing it in a plastic bag when not in use for one (1) of two (2) residents observed for respiratory care. Resident #76.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Oxygen Policy, (undated) revealed, . It is the policy of this facility that oxygen will be utilized as follows: . With the specific physician orders . Date the tubing .</p> <p>A record review of Resident #76's Admission Record revealed that the facility admitted the resident on 01/18/23. The resident had diagnoses that included Chronic Diastolic (Congestive) Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation.</p> <p>A record review of Resident #76's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 11, which indicated that the resident's cognition was moderately impaired. Section O of the MDS indicated that Resident #76 received oxygen therapy.</p> <p>A record review of Resident #76's 10/16/24 Medication Review Report, revealed physician orders, dated 8/27/24, to change the oxygen (O2) tubing and wash the filter every week on Fridays.</p> <p>During an observation on 10/15/24 at 12:08 PM, Resident #76 was observed receiving oxygen via nasal cannula at 2 liters per minute. The oxygen tubing was not dated. The resident reported that she must wear oxygen at all times.</p> <p>During an observation on 10/15/24 at 3:00 PM, Resident #76 was observed lying in bed wearing oxygen via nasal cannula. The oxygen tubing was still not dated.</p> <p>During an observation on 10/16/24 at 9:35 AM, Resident #76 was not in her room, and the nasal cannula was observed lying on top of the oxygen concentrator, without any type of storage to prevent contamination of the tubing and nasal cannula. The oxygen tubing continued to be undated.</p> <p>During an observation and interview on 10/16/24 at 1:30 PM, Registered Nurse (RN) #4 observed that Resident #76's oxygen tubing was not dated, nor was there a plastic storage bag present. RN #4 confirmed that oxygen tubing is to be changed weekly, dated, and stored in a plastic bag when not in use.</p> <p>During an interview on 10/16/24 at 1:45 PM, Licensed Practical Nurse (LPN) #5 explained that Resident #76 is to wear her oxygen at all times, especially while in bed, but the resident removes it when attending activities. LPN #5 added that when oxygen is not in use, the tubing should be stored in a plastic storage bag and that all tubing should be changed and dated weekly, with the filter cleaned. She mentioned that either the cart nurse or the treatment nurse is responsible for changing the tubing and cleaning the filter.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 3:15 PM, RN #1 stated that all oxygen tubing should be stored in a plastic bag when not in use, and that the tubing and bag should be changed weekly to minimize infection risks for the resident.</p> <p>During an interview on 10/17/24 at 2:25 PM, the Director of Nursing (DON) stated that she expects all staff to adhere to the facility's policies and procedures and follow standards of practice for all residents receiving respiratory care. She confirmed that oxygen tubing should be changed and dated each Friday and stored in a plastic bag when not in use.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>37415</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents received meals that were palatable and served at an appetizing temperature for three (3) of ten (10) residents observed for dining. Resident #63, Resident #85, and Resident #90.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Meal Service, dated 12/23, revealed: .Food will be delivered promptly to ensure safe, palatable, and high-quality food served at the appropriate temperature .Procedure .6. Food will be served at palatable temperatures (hot food hot and cold food cold) as discerned by the patients/residents and customary practice .</p> <p>Resident #63:</p> <p>During an interview on 10/15/24 at 11:42 AM, Resident #63 stated that he was not pleased with the meals, describing them as hit or miss and noting that only one (1) out of (10) meals were good. He explained that by the time food arrived at his room, it was cold, sometimes warm, but often was not warm.</p> <p>During an interview on 10/16/24 at 9:03 AM, Resident #63 stated that his breakfast that morning, which included a biscuit, sausage, eggs, and grits, was lukewarm. He mentioned that the two (2) slices of pizza he had received were also lukewarm, although they tasted acceptable.</p> <p>During an interview on 10/16/24 at 3:10 PM, Resident #63 recalled his lunch, which consisted of chicken patties, greens, black-eyed peas, and cornbread. He stated that the food was lukewarm, noting that the black-eyed peas were bland and could benefit from added seasoning like ham. He shared that he mixed mayonnaise with his peas to improve the taste.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #63 on 02/27/23 with diagnoses including Diabetes Mellitus.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/24 revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated he was cognitively intact.</p> <p>Resident #85</p> <p>During an interview on 10/15/24 at 11:10 AM, Resident #85 stated that the food was either too salty or had no taste. She emphasized that she preferred her food to have more flavor.</p> <p>During an interview on 10/15/24 at 12:20 PM, Resident #85 reported that she had not eaten her lunch because it lacked taste and seasoning.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #85 on 11/03/23 with diagnoses including Hypertensive Heart Disease.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 1:26 PM, the Administrator acknowledged residents' complaints about the salty food but was unaware of complaints about the food's bland taste or temperature. She stated that the facility had contracted with an outside company to train the kitchen staff on proper cooking techniques and recipe use.</p>		

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NAME OF PROVIDER OR SUPPLIER MS Care Center of Morton		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43283</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to handle linens in a manner to prevent the possible spread of infection (Resident #12) and failed to wear appropriate Personal Protective Equipment (PPE) during administration of a bolus feeding for a resident that required Enhanced Barrier Precautions (EBP) (Resident #56) for two (2) of 22 sampled residents.</p> <p>Findings include:</p> <p>A review of the facility policy titled Infection Control, dated 09/2022, revealed: .The facility has established and will maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program (IPCP) will include, at a minimum the following elements .Linens. Personnel will handle, store, process, and transport linens so as to prevent the spread of infection .</p> <p>A review of the facility's policy Enhanced Barrier Precautions dated 03/13/24 revealed . Use of Enhanced Barrier Precautions can effectively reduce the spread of Multi-drug resistant Organism (MDRO), specifically those CDC (Center for Disease Control and Prevention) targeted organisms . Definition: Enhanced Barrier Precautions: include use of gowns and gloves for those residents that would not already be in Contact Precautions. It also could include eye covering if there is an anticipation of a splash . Indwelling medical device: Devices such as central lines, PICC (Peripherally inserted central catheter) lines, urinary catheters, feeding tubes, tracheostomy/ventilator require EBP .</p> <p>Resident #12</p> <p>During an observation and interview on 10/16/24 at 10:07 AM, Certified Nurse Aide (CNA) #1 had completed incontinence care on Resident #12. There were dirty linens and a soiled brief directly on the floor of the resident's room. She confirmed she had placed the dirty items on the floor and agreed they should not have been placed directly onto the floor.</p> <p>During an interview on 10/16/24 at 2:10 PM, Licensed Practical Nurse (LPN) #2, confirmed CNA #1 should not have placed the dirty linens and brief directly onto the floor.</p> <p>During an interview on 10/16/24 at 2:27 PM, Registered Nurse (RN) #1, the Infection Preventionist (IP), explained that dirty linens should not be on the floor because it could cause infection to be spread to the residents.</p> <p>During an interview on 10/16/24 at 2:48 PM, the Director of Nursing (DON) stated that dirty linens should not come in contact of the floor due to infection control concerns.</p> <p>A record review of Resident #12's Admission Record revealed that the facility admitted Resident #12 on 03/10/21 with diagnoses including Type 2 Diabetes Mellitus.</p> <p>Resident #56</p> <p>(continued on next page)</p>		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/16/24 at 09:25 AM, Resident #56 was lying in bed and there was signage on the resident's room door that indicated he required EBP.</p> <p>On 10/16/24 at 11:00 AM, during an observation and interview, LPN #4 administered Resident #56's bolus feeding per a Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #4 wore gloves while administering the feeding and did not have a gown on. She stated that because there was no chance of being splashed, she was required to only wear gloves. She confirmed the signage on the resident's door indicated that gloves and gowns should be worn, but reiterated that she had been instructed that she only needed to wear gloves.</p> <p>On 10/16/24 at 03:30 PM, during an interview with RN #1, she confirmed a gown, and gloves were required to be worn when administering feedings or medication via a PEG tube. She also confirmed the facility's policy and the signage on the door indicated the correct PPE worn for EBP (gown and gloves).</p> <p>At 02:15 PM on 10/17/24, during an interview with the DON, she confirmed the staff should wear a gown and gloves for residents with peg tubes. She stated she expected all staff to follow the facility's policies and procedures regarding EBP.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #56 on 04/15/24 with diagnoses including Encounter For Attention To Gastrostomy and Gastrostomy Status.</p> <p>A record review of the Medication Review Report revealed Resident #56 on had a Physician's Order, dated 9/3/24, for .Enhanced Barrier Precautions D/T (due to) Feeding Tube .</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/24 revealed in Section K that Resident #56 had a feeding tube.</p> <p>50751</p>