STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A414	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Sepcialty Care Center	1 Layfair Drive Suite 500 Flowood, MS 39232

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and facility policy review the facility failed to develop and implement a comprehensive person-centered care plan that addressed a resident's documented and known pattern of refusing bath care for one (1) of (1) residents reviewed for care planning (Resident #27). Findings include:Record review of the facility policy Care Plans revised 2/13/25 revealed, .The plan of care should be reviewed and/or updated after each quarterly and comprehensive review as well as with any when changes in treatments and/or needs arise.4. Upon identification of a change in status the Minimum Data Set (MDS) nurse and the Interdisciplinary Team (IDT) should discuss the resident condition and collaborate on intervention options, updating/modifying the care plan as needed. a. The MDS Coordinator will determine whether a significant change in status assessment is warranted.A record review of the comprehensive care plan revealed that it did not address Resident #27's documented and known pattern of refusing bath care. The care plan contained no measurable goals, no interventions specific to managing or responding to refusal of hygiene care, and no documentation reflecting the resident's exercise of his right to refuse treatment.During an observation at 11:29 AM on 6/3/26 observed Certified Nursing Assistant (CNA) #2 and CNA #3 enter Resident #27's room to provide a bath. At this time the resident began shaking his head No multiple times and CNA # 2 and CNA #3 asked the resident if they could provide a bed bath and he refused to allow care to be provided. An interview at 11:31 AM on 6/3/26, with CNA #2 and CNA #3 revealed Resident #27 refuses care at times and they always notify the nurse when he refuses care.An interview with Licensed Practical Nurse (LPN) #1 at 11:33 AM, on 6/3/26 revealed the resident refuses care at times sometimes including baths and will refuse to get up to his chair or will get up then immediately want back in to the bed. She noted that he is always very alert and cognizant of what is going on in his room but is nonverbal so he uses head nods to communicate his wishes.An interview with the Director of Nursing (DON) on 6/3/26 at 3:00 PM confirmed missing days with no documentation of baths dating back to March as well as days where CNAs marked NA (Not Applicable) or RR (Resident Refused). She stated that baths should be documented by the CNA each shift whether they are provided or refused. She noted that the resident typically refuses baths at times but noted they had issues in the past where CNAs had to be reminded to document refusal. She confirmed that the resident is known to often refuse care and the family has been notified. An interview with the resident's sister at 3:35 PM on 6/3/26 revealed she visited the resident recently. She thinks around March and she noticed the resident had a foul odor. She noted that she was concerned he wasn't being bathed. She also explained that she had discussed this concern with the Interdisciplinary Team during care plan meetings in the past.An interview at 10:01 AM with the DON on 6/4/26 revealed the resident's CNAs had been documenting baths in two different spots. Some were documenting under shoulder/bath, and some were under tub/shower. She noted that CNAs were documenting either NA or RR when the resident refused care.An interview with the DON at 11:20 AM on 6/4/26 revealed the person responsible for updating care plans is the Minimum Data Set (MDS) nurse who updates them quarterly and as needed if new problems arise. She noted that failure to (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	update care plans with new concerns could lead to residents receiving inadequate care. She also stated that it is her expectation that staff communicate needs appropriately to the care plan nurse so the care can be added to each resident's care plan.An interview at 11: 37 AM with the MDS nurse on 6/4/26 revealed she is responsible for updating the care plan for nursing on each resident. She noted that each discipline updates problems and interventions for each resident, for example she writes nursing interventions, Respiratory writes respiratory interventions, and dietary writes dietary interventions. She confirmed that the comprehensive care plan did not address the resident's frequent refusal of baths. She noted that the importance of maintaining an up-to-date care plan is to keep staff informed of ongoing problems with interventions to address them. She noted that a complication of not updating a care plan correctly could be that the resident does not receive appropriate care. She also noted that staff never came to her to inform her of the resident's refusal of care to specifically add it to the care plan.An interview at 11:45 AM on 6/4/26 with Registered Nurse (RN) #1 on 6/4/26 revealed that the resident frequently refuses baths, wound care, and at times refused to get up into his wheelchair. She noted that she never specifically notified the care plan nurse of his refusal of care, She explained that it was up to the CNAs to notify the floor nurse of refusal so they can try to educate the resident on the importance of hygiene, however, she noted that she could have gone directly to the care plan nurse to discuss this issue.An interview with the CNA coordinator (LPN #1) at 11:50 AM on 6/4/26 revealed Resident #27 had been refusing baths at times for the past year. She noted that while she never specifically told the care plan nurse that the resident had a problem with refusing baths, the IDT and family have discussed this multiple times during care plan meetings where they meet with the care plan nurse and discuss ongoing issues or health concerns quarterly.A record review of the admission Record revealed Resident #27 was admitted on [DATE] with diagnoses that included intracranial injury.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/1/26 revealed the resident was unable to perform a Brief Interview for Mental Status due to being nonverbal.A record review of the bath log covering the last three (3) months revealed that Resident #27 had one (1) documented refusal on 3/19/26 and refusals in April included 4/7/26, 4/8/26, 4/9/26, 4/12/26, 4/13/26, and 4/26/26. Refusals in May included 5/8/26, 5/9/26, 5/19/26, 5/20/26, and 5/21/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interviews, and facility policy review, the facility failed to ensure a resident's environment remained as free of accident hazards to prevent accidents for one (1) of (1) residents reviewed for falls and accident prevention. (Resident #39). Findings include:A record review of the facility policy, Fall Assessment and Prevention dated 5/14/25, reveals, .II. Procedure .Prior to turning resident, upper side rails should be fully raised and in locked position .A record review facility reported an incident (FRI) #2974987, to the Complaint Unit on 4/4/2026, titled Risk Management Accident/Incident Investigation Summary. The summary revealed that Resident #39 sustained a fall during activities of daily living (ADL) care. Upon the facility investigation and an interview with Certified Nursing Assistant (CNA)#1 involved, it was determined that one of the side rails on the left may not have been fully engaged at the time of the incident. As a result, Resident #39 fell to the floor in a supine position, sustaining a 2cm (centimeter) laceration to the scalp with bleeding. In an interview with the Registered Nurse (RN) on shift at the time of the incident (RN #1) at 1:15 PM on 6/3/ 2026, she described that the incident occurred between 5:00 AM and 6:00 AM on 4/4/2026. Following her medication pass, CNA #1 informed her that Resident #39 was on the floor. Upon entering the room, she observed Resident #39's leg resting on the bottom left rail with the rest of his body on the floor and blood near his head. The bottom left rail was raised; the top left rail was down. She noted that as a routine part of her own practice, she ensures rails are locked by pulling up on each one to confirm they are secure. She also noted that Resident #39 is obese and emphasized the necessity of keeping rails up and ensuring they are locked for this resident. In an interview with CNA #1 on 6/3/26 at 2:00 PM, she recalled the incident, which occurred on 4/4/2026, in the early morning hours after 4:00 AM. She entered Resident #39's room for general rounds and to provide a bath near the end of her shift. After positioning the bed and completing care to the top portion of the resident's body, she prepared to lower the top right rail to reposition the resident to his side, while the remaining rails remained raised. As she pulled the top sheet to reposition Resident #39, he unexpectedly slid over the left side and landed on his back with his head striking the feeding pole. One leg came to rest on the bottom left rail. She noted Resident #39 did not exhibit any facial grimacing. The top left rail had dropped partially. She opened the door and informed a nearby nurse of the situation.CNA #1 further stated that going forward, she would physically check each rail to confirm it is locked before beginning care. She admitted that she had not done this in the past because it had never been an issue.In an interview with the Certified Nursing Assistant (CNA) Coordinator/Licensed Practical Nurse (LPN #1) at 3:10 PM on 6/3/2026, she stated that staff are educated during orientation regarding the importance of ensuring side rails are in the locked position when providing care. She acknowledged that all staff are required to check rails before moving residents. In an interview with the Director of Nursing (DON) at 3:41 PM on 6/3/2026, she stated that it has always been standard procedure to check bed rails before providing any care to residents and that every new hire is trained on this protocol during orientation and receives annual reminders. She reveals that this important to ensure the safety of the resident.A record review of the local hospital provider notes dated 4/4/2026, revealed the following imaging findings: small right frontal scalp hematoma near the vertex.A record review of the Orientation Checklist revealed the following entry for Day 3: Please ensure side rails are up and secured prior to care. CNA #1 acknowledged this requirement by signing on 2/20/26.A record review of the admission Record revealed the facility admitted Resident #39 on 7/20/22, with diagnoses including Anoxic Brain Damage, Not Elsewhere Classified, and Persistent Vegetative State.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/27/2026, revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating Resident #39 was unable to complete the cognitive assessment, consistent with the resident's persistent vegetative state diagnosis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, the facility failed to procure, store, prepare, distribute, and serve food under sanitary conditions for two (2) of four (4) survey days. Specifically, the facility failed to ensure deteriorating fruits and vegetables were removed from food storage and service areas and failed to properly clean and sanitize a food thermometer between food items during food temperature monitoring. Findings Include:A record review of the facility's policy, Food Receiving and Storage policy, effective December 2016, revealed Food shall be received and stored in a manner that complies with safe food handling practices .A record review of the facility's policy, Preventing Foodborne Illnesses Food Handling policy effective December 2016 revealed Food will be stored prepared and handled and served so that the risk of food borne illness is minimized .On 6/1/26 at 10:02 AM, observed two 1-pound boxes of strawberries in the refrigerator with received and storage dates of 5/30/2026.The strawberries were moldy and deteriorating. The Dietary Manager (DD1) confirmed the strawberries were deteriorated and reported dietary staff were responsible for inspecting produce upon receipt and throughout storage.On 6/1/26 at 10:04 AM, during an observation, a clear container of lemons in the refrigerator contained three lemons that were soft to the touch and deteriorating. DD1 reported the lemons had been used on the salad bar earlier that day.On 6/1/26 at 10:06 AM, during an observation, a three-pound bag of tangerines with a received date of 5/27/2026 contained several overly ripe, soft, and deteriorating tangerines. DD1 reported tangerines were prepared and served based on resident requests.On 6/1/26 at 10:07 AM, during an observation, a clear zip-lock bag containing three tomatoes packaged on 5/30/2026 included one tomato that had begun to deteriorate. DD1 reported produce was used daily and staff were responsible for inspecting and discarding deteriorating items.On 6/1/26 at 10:08 AM, during observation, a box of romaine lettuce contained both fresh leaves and leaves that had begun to break down within the same container. DD1 reported staff stocking the salad bar were responsible for discarding deteriorated lettuce leaves.On 6/1/26 at 10:10 AM, during an observation, 27 cartons of reduced-fat milk with a Best By date of 5/31/2026 were present. DD1 reported the date reflected a Best By date and the milk remained acceptable for use based on manufacturer guidelines and facility practices.On 6/1/26 at 10:12 AM, during an observation, three deteriorating tangerines were present on a resident snack cart located in the dry goods room. DD1 removed the deteriorating tangerines from service during the observation.On 6/3/26 at 9:45 AM, an interview with Registered Dietitian (RD) revealed the Dietary Manager was responsible for supervising dietary staff, monitoring food storage practices, and ensuring compliance with dietary procedures.On 6/3/26 at 10:45 AM, during an observation, DD1 used the same alcohol wipe to clean a food thermometer between multiple food temperature checks, including steamed rice, potato casserole, and cabbage. DD1 did not obtain a new wipe between uses and then obtained a different wipe after questioning. The thermometer was not cleaned and sanitized between food items.On 6/4/26 at 1:05 PM, an interview with the Administrator revealed expectations were for dietary staff to inspect and discard deteriorating produce prior to use and to conduct inspections prior to food distribution to ensure deteriorated produce was removed from service areas.

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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, record review, interview and facility policy review, the facility failed to ensure proper hand hygiene practices were performed during urinary catheter care for one (1) of (1) resident observed with an indwelling urinary catheter. Resident #12.Findings included: A record review of facility policy Handwashing/Hand Hygiene revised 12/30/24 revealed, All staff should perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .6. e. Before and after handling an invasive device (e.g., urinary catheters.) On 6/2/26 at 1:33 PM, Resident #12 was observed for foley catheter care provided by Certified Nursing Assistant (CNA)#4. While providing care, CNA#4 cleansed the catheter three times with wipes before removing her gloves and applying new gloves without performing hand hygiene in between. She then cleansed the penis with cleansing wipes and removed her gloves once more and applied new gloves without performing hand hygiene and cleansed the site again with wipes. In an interview with CNA #4 at 1:37 PM on 6/2/26 she confirmed that she forgot to perform hand hygiene during catheter care each time she changed gloves. She noted that the consequences of not changing gloves could lead to infections of the catheter or a urinary tract infection for the resident. An interview with the Director of Nursing (DON) at 2:10 PM on 6/3/26 revealed staff should always perform hand hygiene any time they remove their gloves to avoid the risk of spreading infection to residents. She noted that wearing gloves does not replace the need for hand hygiene. An interview at 10:40 AM on 6/4/26 with the Infection Preventionist revealed that CNA #4 should have performed hand hygiene with each glove change to avoid spreading contamination or infection to the resident's catheter site. She stated each time they remove their gloves; they are potentially dragging bacteria from the catheter site across their hands. Failing to properly clean their hands appropriately, puts the resident at risk for a urinary tract infection. Record review of the admission Record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses that included anoxic brain injury. A review of the Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 4/8/26 revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS) due to vegetative state. A record review of the Order Summary Report with active orders as of 6/2/26 revealed an order dated 8/5/24 Clean foley cath (catheter) daily and prn (as needed) with soap and water or with peri wipes.