STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	**96 OLD HIGHWAY 80 EAST , MORTON, Mississippi, 39117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #3091465) at the facility from 7/20/26 through 7/21/26. CI MS #3091465 was a Facility Reportable Incident investigated related to Accidents. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F689. The facility held a license for 120 beds, with a census of 99.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, record review, review of the facility's investigation, and facility policies review, the facility failed to develop and implement adequate supervision and individualized interventions to prevent an avoidable accident after identifying Resident #1's pattern of sitting at the facility's exit door with his hand on the door handle and documenting that he should not go outside unassisted. As a result, Resident #1 exited the facility without staff knowledge or supervision for approximately three (3) minutes on July 11, 2026. This deficient practice affected one (1) of three (3) residents reviewed for elopement risk. Resident #1. Findings include:	F0689		

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 reverse for further 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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F0689 SS = D	Continued from page 1 Record review of the facility's policy titled, "Wandering and Elopements," revised March 2019, revealed, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents..." Record review of the facility's policy titled, "Accidents," dated December 2009, revealed, "…This facility will commit to safety and address resident risk and environmental hazards in order to minimize the likelihood of avoidable accidents by using an interdisciplinary systems approach… Evaluation and Analysis-Staff will evaluate hazard and accident risk data, analyze potential causes and identify or develop interventions. Ex (example)…Elopement…Implementation of Interventions-Supervision will be provided to prevent avoidable accidents…" Record review of the facility-reported follow-up investigation revealed that on 7/11/26, Resident #1 was sitting near the facility's exit door with his hand on the door handle. A staff member entered the access code and entered the facility through the opposite door. The staff member heard the door click shut but was unaware that Resident #1 was holding and pushing on the door handle. At 11:09:59 AM, Resident #1 exited the facility and went onto the back porch. At 11:10:12 AM, a housekeeping staff member came around the corner and observed Resident #1 outside the facility. The housekeeping staff member assisted Resident #1 back inside and immediately reported the incident to the charge nurse. The incident was verified through review of the facility's surveillance camera footage. Resident #1 Record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 1/5/22 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed a Brief Interview for Mental Status (BIMS) score of two (2), indicating severe cognitive impairment. A record review of the Elopement Risk Evaluation, dated May 5, 2026, revealed Resident #1 was assessed as "NA (Not Applicable)," indicating the interdisciplinary team determined the resident was not at risk for elopement.	F0689		

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F0689 SS = D	Continued from page 2 Record review of the “View Progress Note” dated 7/11/26 at 2:23 PM revealed that Housekeeper #1 reported to the charge nurse that Resident #1 had been found outside in the porch area near the laundry exit without staff supervision and was brought back inside the facility. Staff moved Resident #1 to a more populated area and assessed him, with no apparent injuries identified. Staff initiated safety checks every 15 minutes for 24 hours, followed by hourly checks for seven days. The medical provider, Resident Representative, and Director of Nursing (DON) were notified. On 7/20/26 at 1:22 PM, during an interview with Housekeeper #1, revealed that on 7/11/26, she observed Resident #1 seated in his wheelchair outside the facility, approximately 15 steps from the rear exit doors near the ambulance entrance/exit. She immediately approached Resident #1, assisted him back into the facility, and notified the charge nurse. She reported that Housekeeper #2 was also present during the incident. She further revealed that Resident #1 did not appear to be injured and was initially hesitant to return inside when she approached him. On 7/20/26 at 1:33 PM, during an interview, Housekeeper #2 reported that Resident #1 frequently sat near the rear exit door with his hand on the door handle. He stated that before Resident #1 exited the facility on 7/11/26, he observed the resident seated in his wheelchair near the exit door with his hand on the door handle. Housekeeper #2 reported that when he entered the facility, he heard the exit door click shut and was unaware Resident #1 was holding the door handle, preventing the door from latching securely. He stated he was unaware Resident #1 intended to exit the facility. Housekeeper #2 further reported observing Housekeeper #1 assisting Resident #1 back into the facility. He stated Resident #1 was initially hesitant to re-enter the facility; however, Housekeeper #1 guided him inside and immediately notified the nurse. Housekeeper #2 confirmed the rear porch area was not intended for unsupervised resident use. On 7/20/26 at 2:00 PM, the State Agency (SA) reviewed the facility’s video surveillance with the DON. The video revealed that on 7/11/26 at 11:06:30 AM, Housekeeper #2 entered the facility while Resident #1 was seated in his wheelchair inside the facility with his hand on the exit door handle. After Housekeeper #2 entered and released the door, Resident #1 pushed the door open and began independently propelling his wheelchair with his feet	F0689		

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F0689 SS = D	Continued from page 3 through the exit door. At 11:07:33 AM, Resident #1 was observed outside the facility, approximately 30 feet from the exit, propelling his wheelchair with his feet. At 11:10:30 AM, Housekeeper #1 observed Resident #1 outside without staff supervision. Housekeepers #1 and #2 then assisted Resident #1 back inside the facility, and Housekeeper #1 immediately notified Resident #1's nurse. The surveillance video confirmed Resident #1 exited the facility independently and remained outside without staff knowledge or supervision for approximately three (3) minutes until discovered by Housekeeper #1. The SA observed that the area where Resident #1 was located was a covered outdoor porch adjacent to the facility's rear exit. The porch measured approximately 10 feet by 10 feet, had a concrete surface, and was large enough to accommodate several outdoor lawn chairs. On 7/20/26 at 3:15 PM, during an interview, the DON acknowledged the interdisciplinary team had assessed Resident #1 as not at risk for elopement prior to the incident. The DON further acknowledged that after the incident the resident was reassessed, additional supervision interventions were implemented, and staff were re-educated regarding monitoring residents near the exit doors.	F0689		