Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE , CORINTH, Mississippi, 38834**

(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
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI MS #3158744) at the facility on 10/5/2026 through 10/6/2026. CI MS #3158744 was investigated for supervision. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and and cited M640. The census was 84 with a license for 119 beds.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to implement increased monitoring for signs and symptoms of substance use after becoming aware of Resident #1’s positive drug screen on 7/20/26, for one (1) of three (3) residents reviewed for safety and supervision. Resident #1 Findings Include:Record review of facility policy titled “[Proper Name]” revised 9/2022 revealed, "It is the policy of this facility to provide services based on the following requirements. Facility staff will assess the resident for risk of substance use in the facility and have knowledge of signs and symptoms of possible substance use such as frequent leaves of absence.... changes in resident behavior.... include increased monitoring and supervision of the resident, increased supervision of visitors, and notification of the resident’s physician or non-physician practitioner.” Record review of the Admission Record revealed Resident #1 was admitted to facility on 7/9/2026	M0640		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0640	Continued from page 1 with diagnoses of Stimulant Abuse, Major Depressive Disorder, and anxiety disorder. Record review of "Substance Abuse History" assessment form initiated on 07/21/26, revealed, "Has the resident had a history of substance abuse? Yes" was marked. "What type of recreational/illicit drugs did/does the resident use? Cannabis, Cocaine and Prescriptions," was marked. Record review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated July 2026 and August 2026 did not indicate that any monitoring was being conducted for signs and symptoms of the resident's substance abuse history or assigned as tasks for staff to document. Record review of Progress Notes dated 7/20/26 at 11:29 AM revealed, “Returned from leave per private vehicle and wheelchair.” Record review of Progress Notes dated 7/20/26 at 6:50 PM revealed “Resident exhibiting abnormal rocking, talking, making noises, and abnormal mouth movements. Resident crying and states ‘I’m going to have a heart attack if I don’t get some Ativan.’…order to sent to the ER…” Record review of “Laboratory Results” dated 7/20/2026 revealed Resident #1 had positive urine drug screen for amphetamines, methamphetamine-MDMA, cocaine, and cannabinoids. Record review of Resident #1’s Progress Notes dated 7/29/26 at 3:08 AM revealed, “CNA (Certified Nursing Assistant) notified this nurse that resident was not acting normal. This nurse checked resident blood sugar (BS) and a BS of 33 was observed. Resident was Diaphoretic and Lethargic. This nurse administered emergency glucagon times 2 (two)…Resident sent to (Proper Name) local emergency room (ER) for eval and tx (treatment)…” A Progress note dated 7/29/26 at 6:44 AM revealed resident returned from ER…” Record review of “Medtox Screen” dated 7/29/2026 revealed Resident #1 had positive drug screen for cocaine. Record review of Resident #1’s Progress Notes revealed a note dated 8/12/26 at 6:50 AM revealed “Resident has been making loud growling noises and is semi alert at times. Resident face is more swollen than usual. Vital signs blood pressure	M0640		

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M0640	Continued from page 2 169/87, pulse 103, oxygen saturation 82% on room air, temperature 100.7 and respirations 20. BS 444 sliding scale insulin administered, Report called to (Proper Name) ER and EMS (emergency medical services) is on their way to get resident." Record review of the ER "Laboratory Results" dated 8/12/2026 revealed Resident #1 had positive urine drug screen for amphetamines, methamphetamine-MDMA, and cocaine and was hospitalized on 08/12/26. Record review of the Emergency Department Note dated 8/12/26 revealed, "Chief complaint: Altered Mental Status…Social History…Recreational Drug Use: Marijuana and Methamphetamine…Last Use: a few days ago…Plan: 64 year old female who is here with sepsis secondary to pneumonia along with AKI (acute kidney injury)…Also has encephalopathy suspected to drug use…" During an interview on 10/5/2026 at 2:52 PM, Registered Nurse (RN) #1 confirmed that on 7/20/2026, she received Resident #1 back to the facility following an evaluation at the hospital. RN #1 confirmed she received paperwork from the hospital visit and was aware that Resident #1's urine drug screen was positive for substance use. When asked what action she took after becoming aware of the positive drug screen results, RN #1 stated, "I didn't do anything." She stated that physicians did not like to be called after hours unless there was a medical emergency. RN #1 confirmed she did not notify the Director of Nursing (DON) of the positive drug screen results or the situation, and she was aware that the resident had a history of substance abuse. During an interview on 10/6/2026 at 9:53 AM, the Minimum Data Set (MDS) Nurse stated that on 7/21/2026, the DON instructed her to develop a care plan for Resident #1 related to substance abuse. She stated that the DON did not discuss specific interventions to be implemented. The MDS Nurse stated that she had to review Resident #1's hospital discharge documentation to determine which substances Resident #1 had tested positive for. She further stated that she completed the care plan as instructed and "just did what I was told." The MDS Nurse stated that she does not enter monitoring orders and did not ensure that monitoring interventions related to Resident #1's substance use was placed on the MAR, TAR or assigned as tasks for staff to document. She confirmed that she did not establish a process for staff to supervise and document monitoring for signs or symptoms related to Resident #1's substance use.	M0640		

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M0640	Continued from page 3 During an interview on 10/6/2026 at 10:30 AM, the Staff Development Nurse stated that she did not provide an in-service to facility staff following Resident #1's positive drug screen on 7/20/2026 and was not instructed to provide one. She stated that she was responsible for providing routine staff in-services, as well as additional in-services as needed when directed by facility management. The Staff Development Nurse stated that she was not made aware of Resident #1's substance abuse concerns in July 2026. She stated that she first became aware of the concerns near the end of August 2026, when the DON instructed her to provide an in-service following Resident #1's hospitalization with positive lab results for substance use. During an interview on 10/6/2026 at 12:22 PM, the Social Worker stated that she was aware upon admission that Resident #1 had a history of substance abuse and confirmed that nothing was implemented at that time. She stated that on 7/21/2026, the DON emailed her and instructed her to complete a substance abuse assessment for Resident #1. The Social Worker stated that she did not discuss Resident #1's positive urine drug screen results with the resident and did not discuss the resident's drug use while out on pass. She stated that she "just asked the questions and entered the information into the computer." The Social Worker stated that she did not discuss with Resident #1's husband concerns related to visitation or the resident's drug use while out on pass. She stated that she did not assess Resident #1 for triggers or indicators of drug use and did not provide staff with information, education, or an in-service regarding Resident #1's substance abuse. The Social Worker further stated that after completing the substance abuse assessment, she did not discuss the assessment with the DON. She stated that no meeting or care plan meeting was held to discuss the assessment or develop interventions for Resident #1. The Social Worker stated that a meeting should have been held following the assessment to develop a plan for the resident and that facility staff should have been educated regarding Resident #1's substance abuse. During an interview on 10/6/2026 at 1:05 PM, Certified Nursing Assistant (CNA) #1 stated that she regularly provided care to Resident #1 and was present on 7/20/2026 when Resident #1 returned to the facility from an outing on pass with her husband. CNA #1 stated that Resident #1 was making faces and rocking back and forth. She stated that she	M0640		

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M0640	Continued from page 4 reported her concerns regarding Resident #1's behavior to the nurse, and Resident #1 was subsequently sent to the hospital for evaluation. CNA #1 stated that she was not present when Resident #1 returned to the facility from the hospital. CNA #1 stated that following Resident #1's hospital visit, she did not receive an in-service or education regarding substance abuse, signs and symptoms of substance use, or resident-specific triggers. CNA #1 further stated that she was not aware of any changes to Resident #1's visitation following the incident or any increased supervision. During an interview on 10/6/2026 at 1:30 PM, the DON stated that she became aware of Resident #1's positive urine drug screen on 7/21/2026. The DON confirmed that she did not initiate staff in-services regarding Resident #1's substance abuse. She confirmed that she instructed the MDS Nurse to develop a care plan related to substance abuse but did not discuss specific interventions to be implemented. The DON further confirmed that she instructed the Social Worker to complete a substance abuse assessment. The DON confirmed that following Resident #1's positive drug screen, she did not ensure that specific monitoring interventions were implemented for staff to monitor and document signs or symptoms related to substance use. She confirmed that she did not ensure monitoring was placed on the MAR or established as a staff task for documentation. The DON stated, "I don't feel like it was my responsibility to do anything because she didn't do the drugs at the facility." She confirmed that she did not implement interventions related to Resident #1's visitation or outings on pass following the positive drug screen. The DON stated that she was not aware that Resident #1 had another positive drug screen on 7/29/2026. She stated that following the 7/20/2026 hospital visit and positive drug screen, she did not feel there was a need to more closely review Resident #1's subsequent laboratory results. The DON stated, "At the time I felt like we had done enough." She further stated that she did not feel that doing anything differently following the 7/20/2026 positive drug screen would have changed anything or prevented Resident #1 from being hospitalized on 08/12/26. The DON further stated that she would not have expected the receiving nurse, who received Resident #1 back from the hospital on 7/20/2026, to have taken any additional action regarding the positive drug screen results. She stated that she did not expect a nurse to call her at home to report that information. Record review of MDS with Assessment Reference	M0640		

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M0640	Continued from page 5 Date (ARD) of 7/16/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13 indicating Resident #1 was cognitively intact.	M0640		