STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HEALTHCARE LLC - SNF	1251 PINEHAVEN ROAD CLINTON, MS 39056

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #27819 and CI MS #28086 at the facility on 4/10/25. 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 requirements related to CI MS #28086 which was investigated for pressure wounds and quality of care and cited M 615 and M 1570. CI MS #27819 was investigated related to accidents and neglect with no deficiencies cited. The facility had a census of 113 and was licensed for 121 beds.	M 000		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Pattern Based on observations, interviews, record reviews and policy reviews, the facility failed to provide wound care in a manner to prevent the possibility of wound infection for two (2) of (2) wound care observations. Resident #1 and Resident #4 Findings Include: A record review of the facility's policy titled "Wound Care "dated 1/2015 revealed "Policy: The purpose of this procedure is to provide	M 615	M615 1. On 4/10/2025, the facility initiated monitoring every shift by Licensed nurse, on Resident #1 and Resident #4, for signs and symptoms of infection, times three (3) days. No signs or symptoms of infection were noted the three (3) day monitoring period. On 4/11/2025, At start of shift Licensed Practical Nurse (LPN)#1 received in-serviced, educated with wound care observation check-off completed,	5/14/25

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M 615	Continued From page 1 guidelines for the care of wounds to promote healing. Procedure: ...After cleaning the wound as ordered, clean the tissue around the wound ..." On 4/10/25 at 11:12 AM during an observation of wound care for Resident #1 by Licensed Practical Nurse (LPN) # 1/Wound Care Nurse and assisted by Certified Nursing Assistant (CNA) #1 revealed LPN #1 cleaned the stage IV pressure injury wound bed from the outer edge toward the inner aspect in a circular motion. She dried wound site with gauze from the outer edge toward the inner wound bed in a circular motion four times and applied clean dressing. On 4/10/25 at 1:55 PM in an observation of wound care for Resident #4 completed by LPN #1 and assisted by CNA #2 revealed LPN#1 cleaned wounds from the outer edge toward the inner aspect three times each in a circular motion. She discarded gauze and used a clean gauze and dried the wound from the outer edge towards the inner area of the wound bed. On 4/10/25 at 2:23 PM in an interview with LPN #1 confirmed that she did not clean Resident #1 and Resident #4 wounds correctly. She stated she should clean the inside and move outer to prevent contaminating the wound. She stated Resident #1 and #4's wounds can get infected by the way she cleaned the wounds. On 4/10/25 at 4:52 PM in an interview with Registered Nurse #1 (RN)/ Infection Preventionist Nurse stated LPN #1 should have cleaned the wound from inner to outer to prevent possibly infecting the wounds. She stated LPN #1 contaminated the wounds. On 4/10/25 at 5:31 PM in an interview with the	M 615	including Proper technique of Cleansing of wound/pressure ulcer to prevent potential contamination of wound, by Registered Nurse (RN). 2. All residents with pressure ulcers who receive wound care have the potential to be affected. 3. On 4/11/2025, RN back up wound care nurse was In-serviced/educated on Proper technique of cleansing of wound/pressure ulcer to prevent potential contamination of wound with wound care observation check-off completed, by Director of Nursing (DON). On 4/12/2025 and 4/19/2025, Weekend nurses who perform wound care received education/In-service on proper technique of cleansing of wound/pressure ulcer to prevent potential contamination of wound with wound care observation check-off completed, by Registered Nurse. 4. Beginning on 4/11/2025, a Registered Nurse will monitor/observe wound care of three (3) residents with pressure ulcers weekly times three (3) weeks, then monthly times two (2) months. To ensure compliance with proper wound care and prevention of contamination. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis x two (2) Months, for review, revisions or resolution of plan. The QAPI committee review of the plan	

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M 615	Continued From page 2 Director of Nursing (DON) stated LPN #1 should clean from inner to outer and dispose of gauze. She stated LPN #1 could possibly spread infection. Resident #1: Record review of the admission record revealed admission date: 06/12/24. Diagnoses: Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia. A record review of Resident #1 Order Summary Report revealed an order dated 4/8/25 "Cleanse stage IV pressure injury to sacrum with Dakins Solution, pat dry. Apply collagen then hydrofera blue and secure with silicone foam dressing every other day and as needed." A record review of Resident #1 Minimum Data Set (MDS) with Assessment Reference Date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident had moderate cognitive impairment. Resident #4: Record review of the admission record revealed an admission date of 02/26/25 with diagnoses of Essential Hypertension and Type 2 Diabetes Mellitus without complications. Record review of the Order Summary Report for Resident #4 revealed an order dated 4/4/25 "Cleanse with Dakin's solution, pat dry. Apply Mupirocin to wound bed and cover with alginate and silicone sacral border dressing daily and prn (as needed), one time a day related to Pressure Ulcer of Sacral Region, Stage 3."	M 615	occurred 04/15/2025, the next review is scheduled for 5/13/2025.	

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M 615	Continued From page 3 Record review of the MDS with ARD: 03/5/25 revealed BIMS score 99 indicating the resident was unable to complete the interview.	M 615		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Pattern Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to provide wound care and incontinent care	M1570	M1570 1. On 4/10/2025, the facility initiated monitoring every shift by Licensed nurse, on Resident #1 and Resident #4, for signs	5/14/25

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M1570	Continued From page 4 in a manner to prevent the possibility of spreading infection by not wearing a gown for Enhanced Barrier Precautions (EBP) during wound care and failing to perform proper hand hygiene during incontinent care. This deficient practice was observed for two (2) of two (2) residents reviewed for infection control practices (Resident #1 and Resident #4). Findings include: A record review of the facility's "Infection Prevention and Control Program" policy dated 8/2017, revealed "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 4 ...b. Staff shall wash their hands before and after performing resident care procedures...." A record review of the facility's policy "Enhanced Barrier Precautions," undated, revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown, and gloves use during high contact resident care activities. On 04/10/25 at 11:12 AM, during an observation of wound care for Resident #1 provided by Licensed Practical Nurse (LPN) #1 (Wound Care Nurse), assisted by Certified Nursing Assistant (CNA) #1, revealed they did not follow Enhanced Barrier Precautions. LPN #1 performed wound care without a gown, and CNA #1 assisted by	M1570	and symptoms of infection, times three (3) days. No signs or symptoms of infection were noted the three (3) day monitoring period. On 4/11/2025, at start of shift, Licensed Practical Nurse(LPN) #1, Certified Nursing Assistant(CNA) #1 and CNA #2 received in-service education on Enhanced Barrier Precautions(EBP) protocols including but not limited to Gown and glove use during high contact resident care activities, by Infection Prevention(IP) RN. On 4/11/2025, at the start of shift, CNA #2 received in-service education on Hand Hygiene/handwashing by Infection Prevention RN. On 4/11/2025, the Infection Prevention RN performed observations/checkoffs on EBP and hand hygiene throughout the shift for LPN#1, CNA#1 and CNA#2. 2. All residents with Enhanced Barrier Precautions with high contact care activities have the potential to be affected. 3. On 4/11/2025, Education/in-service and observation checkoffs were initiated by the Infection Prevention RN and/or Staff Development Coordinator, on EBP and hand hygiene for all direct resident care staff. Education and Check-offs to be completed by 5/7/2025. EBP and hand hygiene education/training for direct care staff upon hire and quarterly beginning on 4/14/2025, by the Infection Prevention RN and/or Staff Development Coordinator.	

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M1570	Continued From page 5 turning Resident #1 without wearing a gown. On 04/10/25 at 2:18 PM, in an interview, CNA #1 stated it slipped her mind to put on a gown while assisting LPN #1 with wound care. She stated she should have applied a gown to protect the wound and acknowledged prior training on Enhanced Barrier Precautions. On 04/10/25 at 2:08 PM, during an observation of incontinent care for Resident #4 provided by CNA #2, she exited the room wearing a gown from prior wound care, removed it in the hallway, and returned to the room with supplies. She did not wash hands or don a new gown but applied gloves and began peri care. Resident #4 had feces in the brief. CNA removed soiled gloves three times but did not perform hand hygiene between glove changes. She continued to provide care, pulling wipes from the package with soiled gloves. CNA #2 finished care, removed gloves, and washed hands before exiting the room. On 04/10/25 at 2:23 PM, in an interview, LPN #1 stated she forgot to wear a gown during Resident #1's wound care. On 04/10/25 at 2:41 PM, in an interview, CNA #2 stated she should have worn a gown and washed her hands before and during care. She confirmed that she used soiled gloves to handle wipes and acknowledged the resident could get an infection from the care provided. On 04/10/25 at 4:52 PM, in an interview, Registered Nurse (RN) 1 (Infection Prevention Nurse) she confirmed that LPN #1, CNA #1 and CNA #2 should have worn gowns before starting care, placing the residents at risk of infection and potential spread to others. She also stated CNA	M1570	4. Beginning on 4/14/2025, a Licensed Nurse will monitor/observe resident care activities for EBP and hand hygiene of three (3) residents with EBP, weekly times three (3) weeks, then monthly times two (2) months. To ensure compliance with EBP precautions and prevention potential spread of infection. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis x two (2) Months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 04/15/2025, the next review is scheduled for 5/13/2025.	

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M1570	Continued From page 6	M1570		

#2 failed to follow proper hand hygiene during incontinent care. The last EBP training was conducted in January 2025.

On 04/10/25 at 5:31 PM, in an interview, the Director of Nursing (DON) stated LPN #1, and the CNAs should have applied gowns prior to care, and that when residents are on EBP, extra precautions are required. She acknowledged possible infection spread due to improper gown use and hand hygiene lapses.

Resident #1:

Record review of the admission record revealed admission date: 06/12/24. Diagnoses: Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia.

A record review of Resident #1 Order Summary Report revealed an order dated 4/8/25 "Cleanse stage IV pressure injury to sacrum with Dakins Solution, pat dry. Apply collagen then hydrofera blue and secure with silicone foam dressing every other day and as needed."

A record review of Resident #1 Minimum Dat Set (MDS) with Assessment Reference Date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident had moderate cognitive impairment.

Resident #4:

Record review of the admission record revealed an admission date of 02/26/25 with diagnoses of Essential Hypertension and Type 2 Diabetes Mellitus without complications.

Record review of the Order Summary Report for

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M1570	Continued From page 7 Resident #4 revealed an order dated 4/4/25 "Cleanse with Dakin's solution, pat dry. Apply Mupirocin to wound bed and cover with alginate and silicone sacral border dressing daily and prn (as needed), one time a day related to Pressure Ulcer of Sacral Region, Stage 3." Record review of the MDS with ARD: 03/5/25 revealed BIMS score 99 indicating the resident was unable to complete the interview.	M1570		