STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI) at the facility on 6/18/25 for CI MS #28635 and CI MS #28671. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid for CI MS #28635 and CI MS #28671 regarding Accidents, Quality of Care, and resident rights and cited F580. At the time of survey, the facility had a census of 56 residents and was licensed for 60 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		7/18/25

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

Electronically Signed | 06/25/2025

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to notify a dialysis clinic of a significant change in a resident's status for one (1) of three (3) residents reviewed for notification of change (Resident #1). Findings include: Review of the facility policy titled "Change in Resident Medical Status," last revised 9/17, revealed a change in medical status is defined as any physical, psychological, and/or medical	F 580	* All residents that are dialysis patients will have a Dialysis Communication form with the change in condition noted on the form prior to going to the dialysis unit. An audit of all dialysis residents was done on 06/18/25 by the Director of Nursing with no change of conditions to report. Resident # 1 is no longer a resident of the facility. * All residents have the potential to be	

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F 580	Continued From page 2	F 580		

deviation as compared to the resident's status as noted in the initial assessment.

During review of a complaint received related to Resident #1, it was revealed that the facility did not inform the dialysis clinic of the resident's fall that resulted in a brain bleed.

Record review of a document dated 2/27/25 from (Proper Name) Medical Center revealed Resident #1 presented to the Emergency Department (ED) related to a fall with injury and was diagnosed with a subdural hematoma and a scalp laceration.

An interview with the Nurse Practitioner on 6/18/25 at 11:00 AM confirmed that Resident #1 obtained a subdural hematoma from the fall that occurred on 2/26/25. She stated she asked one of the nursing staff if the dialysis unit was aware of the fall with the subdural hematoma, and the staff member replied yes. She also confirmed that the dialysis unit needed to be aware of the subdural hematoma to determine if any treatments may need to be altered.

An interview with Licensed Practical Nurse (LPN) #1 on 6/18/25 at 11:41 AM confirmed that the facility communicates with the dialysis clinic using the Nursing Facility/Dialysis Clinic Communication forms and confirmed that the fall with the subdural hematoma that Resident #1 obtained should have been communicated on that form to the dialysis clinic.

Review of the Nursing Facility/Dialysis Clinic Communication form for Resident #1 dated 3/5/25, completed by LPN #1, revealed it was completed by the nursing facility prior to clinic transfer. The section titled "Change in Condition"

affected when outside providers are not notified of a change in the residents condition while at the nursing facility.

* 100% of all nursing staff will be in-serviced by the Director of Nursing or RN Supervisor on the Change in Resident Medical Status policy. The dialysis Communication form will inform the unit of any changes that occurs with the resident during their stay at the facility.
In-servicing and monitoring of the communication form was started by the Director of Nursing on 06/18/2025, daily review of nurses notes and physician orders for all dialysis residents will be done Monday through Friday and any changes that affects a dialysis resident will be audited to be sure the dialysis unit was notified properly.

* The Director of Nursing will monitor all Dialysis change of condition forms weekly times twelve
weeks and any discrepancy will be addressed immediately and in Quality Assurance meeting.
A Quality Assurance meeting was held on 06/18/25 with the Director of Nursing, Administrator, Nurse Supervisor, Medical Records Director, the facility Nurse practitioner, and the Infection Preventionist. QA will be held monthly for three months and quarterly to discuss any further issues with the Dialysis Communication form and to ensure compliance with the policy. .

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contained no documentation of the fall or subdural hematoma diagnosed on 2/26/25. A continued review of the Nursing Facility/Dialysis Clinic Communication form for Resident #1 dated 3/5/25-4/4/25 revealed there continued to be no documentation of the fall or subdural hematoma.

A phone interview with the Clinic Manager Registered Nurse from the dialysis clinic on 6/18/25 at 11:50 AM confirmed that Resident #1 was a patient at the clinic and recalls finding out about the fall when the resident told their staff. She reviewed the communication forms and medical record of Resident #1 and stated she was unable to find any documentation that the dialysis clinic was ever informed that Resident #1 had a subdural hematoma. She stated that residents on dialysis are given heparin, an anticoagulant, during dialysis treatment to thin the blood. She then stated that if the clinic had been made aware, the provider would have been notified prior to dialysis treatment because thinning the blood could increase the risk of bleeding from the subdural hematoma, and staff would have been aware of the need to assess for any changes in status.

Record review of the progress notes for Resident #1 from 2/26/25-3/30/25 revealed no documentation that the dialysis clinic was notified of the subdural hematoma diagnosed after a fall on 2/26/25.

An interview with the Director of Nursing on 6/18/25 at 12:10 PM confirmed that staff should have documented the change in status of Resident #1 having a subdural hematoma to the dialysis clinic because the administration of heparin to thin the blood could have worsened the

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F 580	Continued From page 4 condition. An interview with the Administrator on 6/18/25 at 12:20 PM confirmed that the facility staff should have communicated to the dialysis clinic that Resident #1 had a subdural hematoma. Record review of the "Admission Record" revealed the facility admitted Resident #1 was admitted on 1/17/25 with diagnoses of end-stage renal disease and a history of falling. No diagnosis of traumatic subdural hematoma was listed. Record review of Resident #1's Section C of the Admission Minimum Data Set (MDS) revealed that on 1/24/25 the Brief Interview for Mental Status (BIMS) score was 14, indicating the resident was cognitively intact.	F 580		