MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14RO	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) COMPLETE DATE
M 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 for the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements .The SA investigated CI MS #28635 and CI MS #28671 regarding Accidents,Quality of Care, and resident rights and cited M500. At the time of survey the facility had a census of 56 residents and was licensed for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically	M 500		7/18/25

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M 500	Continued From page 1	M 500		

contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is

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M 500	Continued From page 2	M 500		

given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the

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M 500	Continued From page 3 facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to notify a	M 500	* 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	

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M 500	Continued From page 4 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 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	M 500	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 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	

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M 500	Continued From page 5 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" 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	M 500	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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M 500	Continued From page 6 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 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.	M 500		