STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11CC	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

(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 an annual recertification survey and Complaint Investigations (CIs), MS #29311 at the facility from 06/16/25 through 06/19/25. The SA investigated MS #29311 for quality of care related to treatment, environment and medications not given according to physician orders. 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 and cited M620, M815 and M1570.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to provide peri-care in accordance with professional standards of care for two (2) of four (4) peri-care observations (Resident #9 and Resident #15). Findings included: A review of the facility's policy, "Perineal Care Policy," with a revision date of 1/2010, revealed, "POLICY It is the policy of this facility to provide	M 620	Residents #9 and #15 are receiving proper incontinent care as required. The Director of Nursing (DON) assessed residents #9 and #15 on 6/19/25 with no skin breakdown or signs of infection noted. All residents who require incontinent care have been assessed by DON or Infection Prevention (IP) Nurse between 6/20/25 and 6/23/25 with skin breakdown or signs of infection noted. All residents who require incontinent care have the potential to be affected by this	7/27/25

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M 620	Continued From page 1 perineal cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident skin condition..." Resident #9 On 06/17/2025 at 2:10 PM, during an observation of peri-care for Resident #9 provided by Certified Nursing Assistant (CNA) 1 and assisted by CNA #2 revealed CNA #1 placed items on the nightstand beside the bed without a barrier in place. CNA #1 pulled out four wipes and cleaned the vaginal area front to back, pulling wipes from the pack a total of four times with soiled gloves. Resident #9 had feces in the back of her brief. CNA #1 removed gloves, sanitized hands, and proceeded to perform care in the buttocks area, again pulling wipes from the pack four times after starting care with dirty gloves. They then removed gloves, applied hand sanitizer, put on clean gloves, and applied a clean brief. Upon request by the State Agency to check for cleanliness, CNA #1 removed the brief and wiped a total of six additional times, each with visible smears of feces, until the resident was clean. On 06/17/2025 at 2:23 PM, during an interview with CNA #2, she explained that Resident #9 had smears of feces during the recheck. They stated that inadequate peri-care can lead to skin breakdown. On 06/17/2025 at 2:31 PM, during an interview with CNA #1, she confirmed that smears of feces were present during the recheck. She acknowledged that improper care could result in infection and skin breakdown. On 06/19/2025 at 1:50 PM, during an interview with the Director of Nursing (DON), She	M 620	deficient practice. Certified Nurse Aides (CNA'S) #1, #2 #3 and #4 were in-serviced between 6/20/25 and 6/23/25 on their next scheduled workday in a one-on-one meeting with IP nurse and DON. Skills were demonstrated per the IP nurse and a return demonstration was provided by each CNA. All CNA's were in-serviced on incontinent care by the IP Nurse and DON between 6/20/25 and 6/24/25 with demonstrations, videos with return demonstrations performed by all participants. CNA's were able to verbalize the effects of performing incontinent care that was unsatisfactory such as skin breakdown, the risk of urinary tract infections and uncleanliness. The IP nurse, Staff development nurse and DON will monitor incontinent care on three (3) residents, three (3) times weekly times six (6) weeks then three (3) residents weekly times six (6) weeks beginning 6/20/25 to ensure incontinent care is performed properly. Findings of monitors will be brought to the Quality Assurance (QA) Committee by the DON monthly times three (3) months to ensure compliance maintained beginning 7/25/25.	

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M 620	Continued From page 2 explained that CNAs are expected to follow the procedure for peri-care. She stated that improper care can lead to skin irritation and Urinary Tract Infections (UTIs). A record review of Resident #9's Admission Record revealed an initial admission date of 4/26/2022 and a readmission date of 2/28/2025, with diagnoses including Acute Kidney Failure, Vascular Dementia, and Cognitive Communication Deficit. A record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating the interview was not completed. The MDS dated 6/4/25, Section GG revealed the resident is dependent on toileting and hygiene. Resident #15 On 06/18/2025 at 4:29 PM, during an observation of peri-care for Resident #15 provided by CNA #3 and assisted by CNA #4 revealed CNA #3 placed a barrier on the bedside table. Both CNAs washed hands and applied clean gloves. CNA #3 removed the brief and began care. She wiped the front to back in the groin area on each side, then wiped down the center of the labia one time. She did not wipe down the labial sides again. CNA #3 then sanitized hands, applied clean gloves, and continued care. On 06/18/2025 at 5:44 PM, during an interview with CNA #4, she confirmed that CNA #3 wiped down the center of the vagina only once. They stated proper care requires wiping each labial side front to back, then down the center. She acknowledged this failure could lead to a UTI.	M 620		

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M 620	Continued From page 3 On 06/18/2025 at 5:49 PM, during an interview with CNA #3, she explained they were nervous and forgot to wipe down the sides. She acknowledged that this could result in a UTI for Resident #15. On 06/19/2025 at 1:55 PM, during an interview with the DON, She confirmed CNA #3 should have wiped each labial side and then the middle. She stated failure to do so could cause UTIs or infection and that staff are expected to follow the procedure as trained. A record review of Resident #15's Admission Record revealed an admission date of 7/8/2022, with diagnoses including Urinary Tract Infection and Alzheimer's Disease. A record review of Resident #15's MDS with an ARD of 3/26/2025 revealed a BIMS score of ninety-nine (99), indicating the interview was not completed. Section GG revealed the resident is dependent on toileting and hygiene.	M 620		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to follow established guidelines for dating and	M 815	On June 16, 2025, all unlabeled and undated food items were disposed of by the Dietary Manager. The temperature log for breakfast	7/27/25

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M 815	Continued From page 4 labeling opened food items in the freezer and dry goods storage areas and failed to record food temperatures in the temperature log for breakfast during one (1) of four (4) survey days. This failure resulted in noncompliance with food safety standards and increased the risk of foodborne illness. Findings included: A review of the facility's policy, "Food Storage Labeling," revised February 2015, revealed, "The facility will ensure the safety and quality of food... 1 .All food items not in original package must be labeled...6.ii. Document the date the food is being stored..." A review of the facility's policy, "Monitoring Food Temperatures," policy #FP.8, revised February 2015, revealed "...4. Storage temperatures should be recorded on the Cooked Food Storage Temperature Log..." A record review of an in-service training dated 4/28/2025 revealed that topics included labeling, dating, temperature taking, and recording. On 06/16/2025 at 10:18 AM, during the initial kitchen tour with the Dietary Manager, during an observation, the following was observed: In the freezer, one (1) open, unlabeled box of egg rolls and (1) repackaged but undated bag of biscuits were discovered. In the dry goods area, there was (1) package each of opened and repackaged white cake mix, brownie mix, blueberry muffin mix, gelatin mix, and a five (5)-pack of graham cracker crusts-all without open dates. The temperature log for breakfast on 6/16/2025 did not contain recorded temperatures. The Dietary Manager acknowledged and confirmed all	M 815	was updated by the dietary cook to reflect the temperatures of food for breakfast on June 16, 2025. The Director of Nursing assessed residents on June 19, 2025 and reported no adverse reactions from this deficit practice. All residents that eat food from the Dietary Department have the potential to be affected by this deficit practice. The Dietary Manager was in-serviced on proper food storage labeling and monitoring and recording food temperatures by the Administrator on June 18, 2025. All dietary staff employees were in-serviced on proper food storage labeling and recording food temperatures on June 18, 2025 by the Dietary Manager. The Dietary Manager will make rounds three times a week for three weeks, then weekly for two months to monitor and ensure that food is being stored and labeled properly and temperatures are being recorded daily for each meal beginning June 18, 2025. The Dietary Manager will bring the results of the rounds to the Quality Assurance Committee monthly	

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M 815	Continued From page 5 findings at the time of inspection. On 06/17/2025 at 10:20 AM, during a phone interview with the Registered Dietitian, they explained that they were disappointed with the department's condition during the inspection. They stated their expectations for kitchen staff include following procedures for opening, dating, and labeling stored food items. On 06/19/2025 at 2:30 PM, during an interview with the Administrator, they explained their expectations for the dietary department are to follow facility policies and standard precautions regarding food safety and handling.	M 815	for three months beginning July 25, 2025 to assure continued compliance.	
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.	M1570		7/27/25

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M1570	Continued From page 6 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 Based on observation, interview, record review and facility policy review the facility failed to provide incontinent care in a manner to prevent the possibility of cross-contamination for one (1) of four (4) peri-care observations (Resident #9). Findings included: A review of the facility's policy, "Infection Prevention and Control Program," with a revision date of August 2017, revealed, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection." During an observation of peri-care on 06/17/2025 at 2:10 PM, for Resident #9 provided by Certified Nursing Assistant (CNA) #1 and assisted by CNA #2 revealed CNA #1 placed items on the nightstand beside the bed without a barrier in place. Both CNAs washed their hands and applied clean gloves. CNA #1 pulled out four wipes and cleaned the vaginal area front to back, pulling wipes from the pack a total of four times while wearing soiled gloves. Resident #9 had feces in the back of her brief. CNA #1 then removed gloves, sanitized hands, and continued care in the buttocks area, again pulling wipes	M1570	Residents #9 and #15 are receiving proper incontinent care as required. The Director of Nursing (DON) assessed residents #9 and #15 on 6/19/25 with no skin breakdown or signs of infection noted. All residents who require incontinent care have been assessed by DON or Infection Prevention (IP) Nurse between 6/20/25 and 6/23/25 with skin breakdown or signs of infection noted. All residents who require incontinent care have the potential to be affected by this deficient practice. Certified Nurse Aides (CNA'S) #1, #2 #3 and #4 were in-serviced between 6/20/25 and 6/23/25 on their next scheduled workday in a one-on-one meeting with IP nurse and DON. Skills were demonstrated per the IP nurse and a return demonstration was provided by each CNA. All CNA's were in-serviced on incontinent care by the IP Nurse and DON between 6/20/25 and 6/24/25 with demonstrations, videos with return demonstrations performed by all participants. CNA's were able to verbalize the effects of performing incontinent care that was unsatisfactory such as skin breakdown, the risk of urinary tract infections and uncleanliness.	

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M1570	Continued From page 7 from the pack four additional times after starting care with contaminated gloves. During an interview on 06/17/2025 at 2:23 PM, CNA #2, She explained that CNA #1 pulled additional wipes from the pack while still wearing dirty gloves. During an interview on 06/17/2025 at 2:31 PM, CNA #1, acknowledged that wipes should not have been pulled from the pack with soiled gloves. She confirmed a barrier was not used on the bedside table and that all needed wipes should have been removed prior to beginning care. She stated this was an infection control issue. During an interview on 06/18/2025 at 5:08 PM, Registered Nurse (RN) #1/Infection Preventionist (IP), explained that peri-care should be performed by two people: one clean and one dirty. She stated the clean person should pull out wipes for the dirty person to avoid contamination. She reported that improper peri-care can lead to infection and skin breakdown. During an interview on 06/19/2025 at 1:50 PM, the Director of Nursing (DON) stated CNAs are expected to follow established procedures for peri-care. She confirmed that Resident #9 could develop skin irritation and a urinary tract infection (UTI) due to the improper technique used. She reported that CNA #1 should have placed a barrier and removed wipes prior to beginning care. A record review of Resident #9's Admission Record revealed an initial admission date of 4/26/2022 and a readmission date of 2/28/2025, with diagnoses including Acute Kidney Failure,	M1570	The IP nurse, Staff development nurse and DON will monitor incontinent care on three (3) residents, three (3) times weekly times six (6) weeks then three (3) residents weekly times six (6) weeks beginning 6/20/25 to ensure incontinent care is performed properly. Findings of monitors will be brought to the Quality Assurance (QA) Committee by the DON monthly times three (3) months to ensure compliance maintained beginning 7/25/25.	

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M1570	Continued From page 8 Vascular Dementia, and Cognitive Communication Deficit. A record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating the interview was not completed. The MDS, dated 6/4/25, Section GG revealed the resident is dependent on toileting and hygiene.	M1570		