STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 11/17/2025 through 11/20/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F0578, F0607, F0641, F0695, and F0880. The facility had a census of 108 and was licensed for 121 beds.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F0578		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0578 SS = D	Continued from page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and policy review the facility failed to have an Advance Directive readily available for staff usage if needed for one (1) of twenty-three (23) resident Advance Directives reviewed. Resident #83 Findings include: A record review of the facility policy, "Residents Rights Regarding Treatments and Advance Directive," no date, revealed, " "Policy: It is the resident's right to formulate an Advance Directive, and to accept to refuse or accept medical or surgical treatment. Procedure. 1. On admission, the facility will determine if the resident has formulated an Advance Directive..." On 11/18/25 at 12:25 PM in an interview with License Practical Nurse #2 (LPN) who works in Medical Records confirmed that the advance directive was not in the paper chart. She stated the purpose of having it in the chart is if the resident is unable to cognitively respond it should be in the chart so staff can have access. In an interview with the Director of Nursing (DON) on 11/20/25 at 1:15 PM, stated that Advance Directives are important to have to direct the healthcare of a resident according to his or her wishes. If they are not addressed, a resident could end up receiving more aggressive care than they really want or not receiving the care that they would have wished to have when a certain situation arises and they become incapacitated. A record review of Resident #83's "Admission Record" revealed the facility admitted Resident 83 on 10/10/25 with diagnoses including Other Pulmonary Embolism without Acute Cor Pulmonale and Essential (Primary) Hypertension.	F0578		

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F0578 SS = D	Continued from page 2 A record review of Resident #83's electronic chart revealed it does not contain Advance Directive. A record review of the paper chart revealed it does not contain the Advance Directive. On 11/18/25 at 12:18 PM in an observation of DON reviewing the chart for Advance Directive she confirmed it was not in the paper chart. A record review of Resident #83's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.	F0578		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F0607		

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F0607 SS = D	Continued from page 3 retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to implement its abuse-prevention policy by not completing a written investigation when staff were made aware of suspected physical abuse for one (1) of 21 sampled residents (Resident #106). Findings include: A review of the facility's "Abuse Policy Employee Responsibility" dated 3/21/23, revealed, "…5. The facility will identify and INVESTIGATE all suspicions or allegations of abuse…a. the facility will thoroughly INVESTIGATE all alleged violations under the direct supervision of the Administrator…7. Any alleged incident REPORTED must be investigated…" A review of the facility's "Abuse Investigation Process", dated 3/21/23, revealed, "The investigation will include the following: a. Written report from the person reporting the incident with date of report and date and time of incident (Incident/Accident Report)…d. Signed statements from all witnesses, stating time, date and shift of incident. Documentation of investigation should include: A description of resident's behavior and environment at the time of the incident, injuries present, observation of resident staff's behavior during the investigation…" On 11/17/25 at 2:52 PM, during an observation and interview, Resident #106 was seated in a wheelchair with her sister present. The sister stated she had concerns related to care. She stated that on 11/10/25 at 1:48 PM, she found the resident crying and the resident said someone had pushed her and had been mean to her. She stated she contacted the Director of Nursing (DON), who questioned the resident; the resident responded "yes" when asked if someone had pushed her. She stated the DON and two staff conducted a body audit. She stated the DON placed an intervention requiring a nurse to be present during care. On 11/19/25 at 9:48 AM, during an interview with the DON, she stated Resident #106's sister had reported concerns on 11/10/25 that a staff member was mean and had shoved the resident. She stated the resident is difficult to interview because she will respond "yes" to all questions. She confirmed a full body audit was completed and there were no signs of injury, and the	F0607		

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F0607 SS = D	Continued from page 4 resident was questioned. The DON reported that she did not document the investigation and confirmed the facility's policy required a written investigation and she did not follow policy. On 11/19/25 at 10:45 AM, during an interview with the Administrator, she stated all nurses can complete an incident report. She stated she was aware of the allegation but did not instruct staff to complete a written incident report. On 11/19/25 at 3:52 PM, during a follow up interview with the Administrator, she confirmed all allegations of abuse must be addressed. She stated she had reviewed policy and regulations but also used "common sense" and felt no further action was necessary because the resident "could not communicate clearly." A record review of the "Admission Record" revealed the facility admitted Resident #106 on 9/17/21 with a diagnosis including Aphasia Following Cerebral Infarction.A record review of Resident #106's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed staff assessment for mental status was modified independence – some difficulty in new situations only.	F0607		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641		

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F0641 SS = D	Continued from page 5 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments for one (1) of twenty-three (23) residents reviewed for assessment accuracy (Resident #40). This is evidenced by the facility incorrectly coding the resident as receiving anticoagulant therapy on two consecutive MDS submissions. Findings include: A review of the "MDS Assessment Policy," dated 5/2006, reveals, " It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol..." A record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/25 and 10/9/25 reveals a “yes” indicating the resident is on an anticoagulant. A record review of the physician orders does not reveal Resident #40 received anticoagulant medication. At 11/18/25 at 10:39 AM, in an interview with Licensed Practical Nurse #1 (LPN) who is the MDS Nurse, confirmed that she did code the annual MDS with Assessment Reference Date (ARD) of 7/11/25 and the quarterly MDS with ARD of 10/9/25 wrong and that it was an oversite on her part. She said it is important to ensure accuracy of the coding so that everything about the resident is captured and that the facility uses that information to get paid.On 11/20/25 at 12:36 PM, in an interview with the Director of Nursing (DON), she explained that the MDS informs the facility of the needs of the resident such as the type of care,	F0641		

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F0641 SS = D	Continued from page 6 interventions, diets, fall risk and medication plans. Therefore, ensuring its accuracy is crucial since it's how the facility tailors and delivers the right care for each resident. A record review of the "Admission Record" revealed the facility admitted Resident #40 on 7/15/24 with a diagnosis including Unspecified Congestive Heart Failure.	F0641		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure oxygen-use cautionary signage was posted on or near the resident's door for one (1) of one (1) resident reviewed for respiratory care, Resident #78. Findings included: A review of the facility's policy, "Oxygen Safety," revealed, "…No Smoking' signs must be clearly visible in areas where oxygen is stored or in use." On 11/17/25 at 11:48 AM, during an observation, Resident #78 was lying in bed and receiving oxygen via a nasal cannula at two (2) liters per minute. There was no "Oxygen in Use" sign posted on or near the resident's door. On 11/17/25 at 11:50 AM, during an observation and interview, Registered Nurse (RN) #1 came to the doorway of Resident #78's room and confirmed the absence of cautionary oxygen signage. RN #1 stated that a sign had previously been present and must have fallen off. RN #1 acknowledged that clearly posted signage is necessary for safety. On 11/20/25 at 2:00 PM, during an interview with the Director of Nursing (DON), she stated that oxygen is a highly flammable gas and confirmed that signage identifying oxygen use is necessary to ensure resident	F0695		

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F0695 SS = D	Continued from page 7 and staff safety. A record review of the “Admission Record” revealed the facility admitted Resident #78 on 7/31/25 with diagnoses including Shortness of Breath. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/25 revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Further review revealed he received Oxygen therapy within the last 14-day lookback period. A record review of the “Order Summary Report” revealed Resident #78 had a Physician’s Order, dated 9/9/25 for “Oxygen at two (2) liters via nasal cannula every shift…”	F0695		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880		

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F0880 SS = D	Continued from page 8 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection control guidelines when a Certified Nursing Assistant (CNA) provided catheter care while wearing false fingernails that interfered with glove use and effective hand hygiene for one (1) of four (4) care observations, Resident #5.	F0880		

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F0880 SS = D	Continued from page 9 Findings included: A review of the facility's "Hand Hygiene" policy, dated 7/1/24, revealed, "…All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors..." A review of the facility's "Dress Code" (undated), revealed, "…Long nails should not be worn. Nails should be no longer than the tip of the finger. Fingernails should always be kept clean…" On 11/19/25 at 10:39 AM, during an observation of catheter care for Resident #5, Certified Nursing Assistant (CNA) #1 was observed wearing artificial fingernails approximately two (2) inches beyond the fingertips. She had difficulty placing gloves over the nails, requiring four glove changes during the procedure. Each time gloves were changed, she used hand sanitizer but did not clean underneath the long artificial nails. On 11/19/25 at 10:55 AM, during an interview with CNA #1, she stated that her fingernails were fake and acknowledged that they were very long, causing difficulty when putting on gloves during care. She stated the facility had instructed CNAs during monthly in-service training not to wear long or artificial nails because they can spread infection and may scratch or injure residents. On 11/19/25 at 3:35 PM, during an interview with the Director of Nursing (DON), she stated that staff nails should be kept neatly trimmed per facility policy to prevent the spread of infection caused by bacteria that can live under long or artificial fingernails. On 11/20/25 at 11:00 AM, during an interview with the Infection Preventionist (IP) Nurse, he stated that the facility policy recommends nails be kept no longer than the fingertip. He explained that long nails can harbor bacteria, are difficult to clean under, and can contribute to the spread of infection. A record review of Resident #5's "Admission Record" revealed the facility admitted the resident on 8/11/23 with diagnoses including Encephalopathy. A record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F0880		

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F0880 SS = D		F0880		