STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255282	A. BUILDING _____ B. WING _____	C 07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HEALTHCARE LLC - SNF	**1251 PINEHAVEN ROAD CLINTON, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey for Complaint Investigation (CI) #17415 for Neglect/pressure sores, Infection Control, and Neglect/assess resident, CI #17384 for Injury of Unknown Origin, CI #17859 for Quality of Care (QOC)/not following physician orders, QOC/residents left wet for extended periods, and QOC/call lights not being answered in a timely manner, CI # 17442 for QOC/improper incontinent care, Misappropriaiton of Property/resident personal items missing, Resident rights/no procedure to locate lost clothes, and Resident Rights/not treated with dignity, and CI # 17766 for QOC/no pressure sore precautins and QOC/services not performed per POC from 7/6/21 through 7/7/21. During the survey, the SA did not substantiate the complaints. The facility held a license for 121 beds, with a census of 110.	F 000		

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