

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255282		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/07/2021	
NAME OF PROVIDER OR SUPPLIER CLINTON HEALTHCARE LLC - SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 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, Misappropriation 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 precautions 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	

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 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.