STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and Complaint Investigations (CI MS#16790 and CI MS#18240) was conducted by the State Survey Agency (SSA) at the facility from 10/26/2021 through 10/28/2021. The facility was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The SSA did not substantiate CI MS#16790 and CI MS#18240 related to Quality of Care/Treatment and Resident/Patient/Client Neglect regarding the facility had no prevention of pressure ulcers, staff being rude to resident's and call lights not being answered due to lack of evidence. The SSA cited F636, F638, and F641 in the annual survey. The facility has a license for 75 with a census of 70.	F 000		
F 636 SS=F	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		11/29/21

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

Electronically Signed | 11/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 636	Continued From page 1 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 636	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review the facility failed to complete a comprehensive Minimum Data Set (MDS) for two of 13 residents reviewed for comprehensive assessments, with the potential to affect 70 residents. Resident #11 and Resident #12 Record review of the facility's "MDS Assessment" policy dated 5/2006 revealed, "It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set for by CMS (Centers for Medicare and Medicaid Services) protocol". Record review of CMS's RAI Version 3.0 Manual dated October 2019 indicated "The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) ..." Resident #11 A record review of the "Admission Record" revealed the facility admitted Resident #11 on 10/16/2019, with diagnoses including Huntington's Disease, Dysphagia, and Dementia. A record review of the last completed Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 6/18/2021. Further review of the electronic medical revealed Resident #11's comprehensive annual assessment had not been completed. Resident #12 A record review of the "Admission Record"	F 636	A. The facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for two of 13 residents reviewed for comprehensive assessments. The Director of Nursing immediately completed an MDS Assessment for the 2 residents effected. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will complete the Minimum Data Set assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. B. The potential exists to affect 70 residents. C. An audit of all facility resident□s comprehensive Minimum Data Set (MDS) assessments was completed by the Director of Nursing and Minimum Data Set Coordinator on 10/29/2021 to ensure that required assessments were completed timely and in accordance with the Resident Assessment Instrument (RAI) process. Twenty-six late assessments were found in this audit. These assessments will be completed by the Director of Nursing and Minimum Data Set Coordinator by 11/29/21. The Minimum Data Set Coordinator was in-serviced by the Director of Nursing on 11/10/2021 on use of the RAI manual as a guide for input in the Minimum Data Set assessments for each resident. In the absence of the Minimum Data Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 636	Continued From page 3 revealed the facility admitted Resident #12 on 12/21/2015, with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Systolic (Congestive) Heart Failure, and Atherosclerosis of Aorta. A record review of the last completed MDS revealed a quarterly assessment with an ARD of 6/23/21. Further review of the electronic medical revealed Resident #12's comprehensive annual assessment had not been completed. On 10/28/21 at 11:07 AM, during an interview with the Director of Nursing (DON), she stated the reason the MDS assessments have not been completed is because the facility has experienced recent turnover in the MDS nurse position and the current MDS nurse has been in her current role for only a week. On 10/28/21 at 11:18 AM, during an interview with MDS Corporate Coordinator, Registered Nurse (RN), she stated the current MDS nurse is new. She confirmed there are MDS Assessments that are past due and states she is aware of the issue. She stated throughout the company there has been a shortage of MDS staff and they try to do assessments for Part A (Medicare Part A) residents timely. She stated, "It's a mess, we know". On 10/28/21 at 1:22 PM, during a follow up interview with the MDS Corporate Coordinator, RN, she accessed Resident #11's and Resident #12's electronic MDS using the facility laptop. She confirmed the last completed MDS assessments dates were accurate for Resident #11 and Resident #12. She further stated, "the next ones (next MDS assessments) are open but	F 636	Coordinator, the Director of Nursing will complete the Minimum Data Set assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. The Director of Nursing will perform a review of the Minimum Data Set (MDS) assessment schedule weekly for 3 months starting on 11-01-2021 for all facility residents to ensure accurate and timely completion. D. The Director of Nursing will monitor the completion of Minimum Data Set (MDS) assessments for the facility residents weekly for 3 months starting on 11-01-2021, and report the findings to the Quality Assurance Performance Improvement Committee in the weekly meetings starting 11-04-2021. Necessary changes will be made to maintain sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 636	Continued From page 4 they are not completed". On 10/28/21 at 11:40 AM, during an interview with the Administrator, he stated that his expectations are that Part A MDS assessments have to be completed for residents and Medicaid resident assessments are not as time sensitive and they try to prioritize and work in that fashion. He stated he is aware there are some MDS assessments that are not completed timely. He said they have had turnover in the MDS nurse position.	F 636		
F 638 SS=F	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to complete quarterly Minimum Data Set (MDS) Assessments for ten (10) of 13 residents reviewed for quarterly assessments, with the potential to affect 70 residents. Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 Resident #6, Resident #7, Resident #8, Resident #9, Resident #13 Record review of the facility's "MDS Assessment" policy dated 5/2006 revealed, "It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set for by CMS (Centers for Medicare and Medicaid Services) protocol".	F 638	A. The facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for two of 13 residents reviewed for comprehensive assessments. The Director of Nursing immediately completed an MDS Assessment for the 2 residents effected. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will complete the Minimum Data Set assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. B. The potential exists to affect 70	11/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 638	Continued From page 5 Record review of CMS's RAI Version 3.0 Manual dated October 2019 indicated "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days ..." Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/7/2016, with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, Chronic Kidney Disease, and Type 2 Diabetes Mellitus. A record review of the last completed MDS for Resident #1 revealed a quarterly assessment with an ARD of 5/27/21, which is more than 92 days. Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 8/13/2015, with diagnoses including Chronic Obstructive Pulmonary Disease, Paranoid Schizophrenia, and Type 2 Diabetes Mellitus. A record review of the last completed MDS for Resident #2 revealed a comprehensive assessment with an ARD of 5/28/21, which is more than 92 days. Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on	F 638	residents. C. An audit of all facility resident□s comprehensive Minimum Data Set (MDS) assessments was completed by the Director of Nursing and Minimum Data Set Coordinator on 10/29/2021 to ensure that required assessments were completed timely and in accordance with the Resident Assessment Instrument (RAI) process. Twenty-six late assessments were found in this audit. These assessments will be completed by the Director of Nursing and Minimum Data Set Coordinator by 11/29/21. The Minimum Data Set Coordinator was in-serviced by the Director of Nursing on 11/10/2021 on use of the RAI manual as a guide for input in the Minimum Data Set assessments for each resident. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will complete the Minimum Data Set assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. The Director of Nursing will perform a review of the Minimum Data Set (MDS) assessment schedule weekly for 3 months starting on 11-01-2021 for all facility residents to ensure accurate and timely completion. D. The Director of Nursing will monitor the completion of Minimum Data Set (MDS) assessments for the facility residents weekly for 3 months starting on 11-01-2021, and report the findings to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 638	Continued From page 6 2/26/2021, with diagnoses including Alzheimer's Disease with Early Onset and Essential (Primary) Hypertension. A record review of the last completed MDS for Resident #3 revealed a quarterly assessment with an ARD of 6/1/21, which is more than 92 days. Resident #4 A record review of the "Admission Record" revealed the facility admitted Resident #4 on 6/2/2021, with diagnoses including Transient Cerebral Ischemic Attack, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. A record review of the last completed MDS for Resident #4 revealed a comprehensive assessment with an ARD of 6/8/21, which is more than 92 days. Resident #5 A record review of the "Admission Record" revealed the facility admitted Resident #5 on 5/3/2018, with diagnoses including Unspecified Dementia with Behavioral Disturbance, Paranoid Schizophrenia, and Chronic Obstructive Pulmonary Disease (Unspecified). A record review of the last completed MDS for Resident #5 revealed a quarterly assessment with an ARD of 6/2/21, which is more than 92 days. Resident #6 A record review of the "Admission Record"	F 638	Quality Assurance Performance Improvement Committee in the weekly meetings starting 11-04-2021. Necessary changes will be made to maintain sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 638	Continued From page 7	F 638		

revealed the facility admitted Resident #6 on 6/18/2020, with diagnoses including Other Transient Cerebral Ischemic Attacks and Related syndromes, Atherosclerotic Heart Disease of Native Coronary Artery with Unspecified Angina Pectoris, and Legal Blindness (as defined in USA).

A record review of the last completed MDS for Resident #6 revealed a quarterly assessment with an ARD of 6/2/21, which is more than 92 days.

Resident #7

A record review of the "Admission Record" revealed the facility admitted Resident #7 on 2/7/2019, with diagnoses including Unspecified Dementia with Behavioral Disturbance, Chronic Kidney Disease (Unspecified), and Type 2 Diabetes Mellitus without Complications.

A record review of the last completed MDS for Resident #7 revealed a quarterly assessment with an ARD of 6/9/21, which is more than 92 days.

Resident #8

A record review of the "Admission Record" revealed the facility admitted Resident #8 on 7/19/2019, with diagnoses including Chronic Obstructive Pulmonary Disease (Unspecified) and Other Alzheimer's Disease.

A record review of the last completed MDS for Resident #8 revealed a comprehensive assessment with an ARD of 6/9/21, which is more than 92 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 638	Continued From page 8	F 638		

Resident #9

A record review of the "Admission Record" revealed the facility admitted Resident #9 on 2/11/2019, with diagnoses including Unspecified Psychosis not due to a Substance or Known Physiological Condition and Primary Generalized (Osteo)Arthritis.

A record review of the last completed MDS for Resident #9 revealed a quarterly assessment with an ARD of 6/10/21, which is more than 92 days.

Resident #13

A record review of the "Admission Record" revealed the facility admitted Resident #13 on 3/9/2021, with diagnoses including Transient Cerebral Ischemic Attack (Unspecified), Alzheimer's Disease with Early Onset, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease.

A record review of the last completed MDS for Resident #13 revealed a comprehensive assessment with an ARD of 6/23/21, which is more than 92 days.

On 10/28/21 at 11:07 AM, during an interview with the Director of Nursing (DON), she stated the reason the MDS assessments have not been completed is because the facility has experienced recent turnover in the MDS nurse position and the current MDS nurse has been in her current role for only a week.

On 10/28/21 at 11:18 AM, during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 638	Continued From page 9 MDS Corporate Coordinator, Registered Nurse (RN), she stated the current MDS nurse is new. She confirmed there are MDS Assessments that are past due and stated she is aware of the issue. She stated throughout the company there has been a shortage of MDS staff and they try to do assessments for Part A (Medicare Part A) residents timely. She stated, "It's a mess, we know". On 10/28/21 at 1:22 PM, during a follow up interview with the MDS Corporate Coordinator, RN, she accessed Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #13's electronic MDS using the facility laptop. She confirmed the last completed MDS assessments dates were accurate for those residents. She further stated, "the next ones (next MDS assessments) are open but they are not completed". On 10/28/21 at 11:40 AM, during an interview with the Administrator, he stated that his expectations are that Part A MDS assessments have to be completed for residents and Medicaid resident assessments are not as time sensitive and they try to prioritize and work in that fashion. He stated he is aware there are some MDS assessments that are not completed timely. He said they have had turnover in the MDS nurse position.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		11/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 641	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to accurately code the Minimum Data Set (MDS) reflecting anticoagulant medications for two (2) residents of 17 sampled residents. (Resident #28 and Resident #41) A record review of the facility's policy dated 5/2006 revealed "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 "David Drug Guide for Nurses" Fifteenth Edition 2015 revealed the classification of Clopidogrel (Plavix) is listed as "therapeutic: antiplatelet agents" and "Pharmacologic: platelet aggregation inhibitors". Resident #28 Record review of Resident #28's "Admission Record" revealed the facility admitted the resident on 10/28/2020 with diagnoses including Osteoarthritis, Disorientation, Major Depressive Disorder, Hyperlipidemia, and Hemiplegia and Hemiparesis following Cerebrovascular Disease. Record review of Resident #28's "Order Summary Report" dated 07/01/2021 revealed an order with an order date of 10/28/2020 for Plavix 75 mg daily give one (1) tablet by mouth one time a day related to Hemiplegia and Hemiparesis following Cerebrovascular Disease. There were no anticoagulant medications listed on the "Order Summary Report". Review of Resident #28's Quarterly Minimum	F 641	A. The facility failed to accurately code the Minimum Data Set (MDS) reflecting anticoagulant medications for two (2) residents of 17 sampled residents. (Resident #28 and Resident #41). A modified Minimum Data Set (MDS) assessment was completed on 10/29/21 to correct the coding of the anticoagulant for Resident #28 and Resident #41. A review was completed by the Director of Nursing on 10/29/2021 of all resident Minimum Data Set (MDS) assessments to ensure there were no further incorrect coding of anticoagulant medications. B. The potential exists to affect 70 residents. C. A review was completed by the Director of Nursing on 10/29/2021 of all resident Minimum Data Set (MDS) assessments to ensure there were no further incorrect assessments of anticoagulant medications. The Minimum Data Set Coordinator was in-serviced on 11/10/2021 by the Director of Nursing on appropriate documentation of anticoagulant medications in accordance with the Resident Assessment Instrument (RAI) process. A weekly review beginning 11/01/2021 will be completed by the DON for accurate documentation of anticoagulant medications. This review will be done for three months. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will complete the Minimum Data Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 641	Continued From page 11 Data Set (MDS) with an Assessment Reference Date (ARD) of 7/22/21 revealed coding in Section N as Resident #28 received anticoagulant medication for seven (7) days out of the seven (7) day look back period. Record review of Resident #28's "Medication Administration Record (MAR)" for July 2021 revealed Plavix 75 mg was administered daily and there were no anticoagulant medications administered. Resident #41 Record review of "Admission Record" revealed the facility admitted Resident #41 on 01/21/2019 with diagnoses including Alzheimer's Disease with late onset, Recurrent Depression Disorder, Vascular Dementia with behavioral disturbances, and Mood disorder. Record review of an "Order Summary Report" for Resident #41 for the month of August 2021 revealed a physician order with an order date of 1/12/2019 for Clopidogrel Bisulfate Tablet 75 mg give one (1) tablet by mouth one time a day for coronary artery disease. There were no anticoagulant medications listed on the "Order Summary Report". Record review the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/17/2021 revealed coding under Section N which indicated Resident #41 received an anticoagulant for seven (7) days of the seven (7) day look back period. Record review of Resident #41's "Medication Administration Record (MAR)" for August 2021	F 641	assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. D. The Director of Nursing will monitor the documentation of anticoagulant medications for the facility residents weekly for 3 months beginning 11/01/2021, and report the findings to the Quality Assurance Performance Improvement Committee in the weekly meetings beginning 11/04/2021. Necessary changes will be made to maintain sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	10/28/2021

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) COMPLETION DATE
F 641	Continued From page 12	F 641		

revealed Resident #41 received Clopidogrel Bisulfate Tablet 75 mg daily and was not administered an anticoagulant medication.

Record review of the Facility's MDS medication reference sheet revealed a section heading of "Anticoagulants (Code on MDS [N410E])" in which Clopidogrel Bisulfate is not listed in that section of the reference sheet. The reference sheet also includes a section with the heading "Antiplatelet agents (do not code on MDS [N410E])" in which Clopidogrel Bisulfate is listed in that section.

On 10/28/21 at 11:40 AM, during an interview with the Administrator, he stated that his expectations are that all MDS assessments should be coded correctly. He stated there has been staffing issues and turnover in the MDS nurse position.

On 10/28/21 at 12:00 PM, during an interview with the MDS Corporate Coordinator, Registered Nurse (RN), she explained Plavix is not an anticoagulant medication. She stated the facility has a "cheat sheet" (reference sheet) to assist with accurately coding medications for the MDS. She explained the MDS nurse who completed the assessments for Resident #28 and Resident #41 no longer works for the facility and they are aware of the errors the nurse had made on MDS assessments. She further explained that she has been correcting and reviewing the MDS assessments but has not had time to review and correct inaccurate coding related to medications.