MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a licensure survey at the facility from 3/27/17, to 3/30/17. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M460, M610, M620, and M650. The census at the time of survey was 118 and the facility held a license for 121 beds.	M 000		
M 460	45.16.3 Criminal History Record Checks Criminal History Record Checks. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be preformed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on: 1. Every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 01, 2003, and 2. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer. 3. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending	M 460	M460 • Business Office Manger checked all current employees through the Nurse Aid Registry on 03/28/17 • All Residents have the potential to be affected by this deficient practice. • BOM was in-serviced on 4-21-17 by the Administrator to continue to check all new employees through the Nurse Aid Registry. • All new employees will be checked weekly by the BOM and the Administrator for a 90-day period. The results will be brought to the QA Committee for a 90-day period by the BOM for review. • Completion 5-02-17	

Revised 5-1-17

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 460	Continued From page 1 the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted. 4. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be eligible to be employed at the licensed facility. a possession or sale of drugs b. murder c. manslaughter d. armed robbery e. rape f sexual battery g. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972 h. child abuse i arson j. grand larceny k burglary l. gratification of lust m. aggravated assault n. felonious abuse and/or battery of vulnerable adult 5. Documentation of verification of the employee ' s disciplinary status, if any, with the employee ' s professional licensing agency as applicable, and evidence of submission of the employee ' s fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of	M 460		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 460	Continued From page 2 verification of the employee ' s disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual ' s suitability for such employment. 6. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency shall require every employee of a covered entity employed prior to July 01, 2003, to sign an affidavit stating that he or she does not have a criminal history as outlined in paragraph (3) above. 7. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee ' s personnel file as proof of compliance with this section 8 If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or pleas has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility ' s policies and procedures. 9. The covered entity may, in its discretion, allow	M 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING. _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 460	Continued From page 3 any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity ' s hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references, and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility. 10. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00). 11. Should results of an employee applicant ' s criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant ' s suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi State Department of Health without the necessity of an additional	M 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 460	Continued From page 4 criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant ' s criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history check as required in this subsection. 12. For individuals contacted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check. 13. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officer, employees, attorneys, and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and the facility policy review, the facility failed to properly screen new employees for abuse and neglect through state agencies as evidenced by not checking the Nurse Aide Registry for three (3) of five (5) new employee records reviewed [Employee #1, #3 and #5]	M 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 460	Continued From page 5 Findings include. Review of the facility's "New Hire Required Background Checks" policy, dated 5/1/13, revealed, "Every employee will be checked for abuse at the following web site upon hire. www.asisvcs.com. "Run a check on all employees through this system." Record review for Employee #1 revealed a hire date of 12/5/16. The Nurse Aide Registry was not checked for abuse and neglect. Record review for Employee #3 revealed a hire date of 2/14/17 The Nurse Aide Registry was not checked for abuse and neglect. Record review for Employee #5 revealed a hire date of 3/1/17. The Nurse Aide Registry was not checked for abuse and neglect. On 3/28/17 at 11 40 AM, an interview with the Business Office Manager (BOM) revealed, "I only do the CNA (Certified Nursing Assistant) registry on the CNAs " On 3/28/17 at 2 15 PM, an interview with the BOM revealed, "(Name of Nurse Consultant) told me to use this (check list) with every new person and to go back and check on all the ones I didn't check " On 3/28/17 at 3 50 PM, an interview with the Nurse Consultant/RN (Registered Nurse) #4 revealed, "We will use this (check list) on everybody for the abuse check." On 3/29/17 at 8 00 AM, an interview with the BOM revealed, "Last night I ran a Nurse Aide Registry on everybody that works here "	M 460		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to. 1 Bath, dressing and grooming; 2 Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4 Toileting. This Statute is not met as evidenced by: Level II Based on observation, record review, staff interview, and policy review, the facility failed to provide a total lift sling required for transfers for one (1) of two (2) residents requiring amputee slings for transfer [Resident #16] This was for one (1) five (5) residents reviewed with the use of a lift. Findings include. Review of the "Modified Lifting Policy", dated 3/16, revealed It is the policy of the facility to help lift residents who are unable to be lifted manually and to promote comfort and to maintain proper body alignment while the resident is being moved The need for the use of a lift, type of lift, sling type and size will be determined by the lift assessment. On 3/29/17 at 10.15 AM, an observation and interview with Resident #16 revealed, "I am in the bed all day because they won't get me up I don't	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 610	Continued From page 7	M 610		

know why. I am in the bed, in the bed looking at the ceiling all day." Resident #16 had bilateral above the knee amputations.

On 3/29/17 at 10:20 AM, an interview with Certified Nursing Assistant (CNA) #5 revealed there were two (2) amputee slings in the building. She stated that she could not find one yesterday because one (1) was dirty and another resident had the other sling. CNA #5 stated that Resident #16 did not get up every day. CNA #5 stated she had to check everywhere to find the amputee sling. She stated "I tell the nurse that I didn't get her up because we don't have a sling and she says find one."

On 3/29/17 at 2:15 PM, an interview with Licensed Practical Nurse (LPN) #4 revealed, Resident #16 required total care. LPN #4 stated that Resident #16 goes to dialysis on Mondays, Wednesdays and Fridays and is up in a Geri-chair often; maybe one (1)-two (2) times a week. LPN #4 stated Resident #16 needed an amputee sling and they only have two (2), but another resident uses the amputee sling as well. LPN #4 stated if a CNA tells her they need a sling, she says "find one". LPN #4 stated she had told the previous Director of Nurses (DON) that they needed more slings but had never gotten any. LPN #4 confirmed she had not told the current DON that more slings were needed.

On 3/29/17 at 3:05 PM, an interview with the Activity Director (AD) revealed, Resident #16 goes to dialysis, and if up, she attends group activities on Tuesday and Thursday and enjoyed food socials. The AD did not know why Resident #16 was not up.

On 3/29/17 at 3:25 PM, an interview with the

- Both Residents amputee slings were located per DON/ADON. The slings were replaced and new slings were received on 3/29/17
- All residents that uses amputee slings have the potential to be affected by this deficient practice
- Orders have been put in place for residents who need amputee slings every shift.
- All CNA/LPN/RN were given in-service by the DON on 3/29/17 on appropriate usage of amputee slings and sling storage process
- Ten residents who currently are using slings will be monitored weekly x 3 months by DON/RN unit managers/LPN on proper sling usage per policy. DON will report findings to the QA committee meeting monthly to ensure continued compliance for appropriately placing slings on the residents as ordered.
- Date of completion 5/02/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 610	Continued From page 8 DON revealed Resident #16 required a total body lift for transfers with an amputee sling and didn't know why the resident wasn't getting up. The DON stated there were two (2) amputee slings in the building. On 3/30/17 at 9:25 AM, an interview with the DON revealed sometimes Resident #16 did not remember she had been up and a lot of times she refused to get up. The DON stated that she would like for all the residents to be up. The DON stated, "I will get more slings, there will be no reason they can't get her up." Review of the facility's face sheet revealed, the facility admitted Resident #16 on 2/20/15. Resident #16's diagnoses included End Stage Renal Disease, Peripheral Vascular Disease, Orthostatic Hypotension, Diabetes Mellitus and Bilateral Above the Amputation. Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/17, revealed Resident #16 had a Brief Interview of Mental Status (BIMS) score of 7, indicating the resident had impaired cognition	M 610		
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 Level II Based on observation, staff interview, record	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 620	Continued From page 9	M 620	M620	

review, and facility policy review, the facility failed to provide catheter care in a manner to prevent the possible spread of infection for (2) two of three (3) catheter care observations; Residents #2 and #18.

Findings include:

A review of the facility's "Perineal Care Policy" with a revision date of 12/2009, revealed it is the facility's policy to provide perineal cleanliness and comfort to the resident to prevent infections and skin irritation. "If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches."

Review of the facility's "Catheter Care Instructions" policy, dated 12/09, revealed to cleanse and rinse the catheter from insertion site to approximately four inches outward. "Secure catheter utilizing a leg band."

Resident #2
An observation on 03/28/17 at 10:00 AM, revealed Certified Nursing Assistant (CNA) #2 did not clean Resident #2's catheter tubing during catheter care. CNA #2 applied cream to Resident #2's buttocks, and touched the resident's clean brief without changing gloves.

Interview on 3/28/17 at 10.15 AM, with CNA #2, revealed "I messed up. I was just nervous. I forgot to change my gloves."

Interview with Registered Nurse (RN) #2 on 3/29/17 at 3:55 PM, revealed the facility provided training to the CNAs for catheter care, which included cleaning with soap and water from top to bottom of the catheter tubing, holding the tube

- On 3/28/17 ADON observed catheter care being provided for resident #2 with no infection control infractions identified.
- All residents with catheters have the potential to be affected by this deficient practice.
- CNA were given in-service by the ADON on 3/28/17 on policy and procedure of catheter care.
- DON/ADON will observe 2 residents twice a week x 3 months being provided foley catheter care with no infection control issues identified.

  DON will report findings to QA committee meeting monthly to ensure continued compliance.
- Date of completion 5/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 620	Continued From page 10 while cleaning. Review of the Face Sheet revealed the facility admitted Resident #2 on 10/29/2016, with diagnoses which included Urinary distention. A review of the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/25/2017, revealed Resident #2 scored a 12 on the Brief Interview for Mental Status (BIMS), which indicated moderately impaired cognition. Resident #18 Observation of Foley catheter care on 03/29/17 at 10:55 AM, revealed Certified Nursing Assistant (CNA) #3 performed catheter care on Resident #18 with assistance from CNA #4 Resident #18 did not have a securing device in place prior to catheter care During the catheter care, CNA #3 removed the Foley catheter bag from the side of the bed to reposition the resident to a side lying position. CNA #4 held the Foley catheter bag at her waist level while CNA #3 cleaned Resident #18's buttocks. Upon completion of the catheter care, CNA #3 did not apply a device to secure the catheter tubing. Interview on 3/29/17 at 11 15 AM, with CNA #3, confirmed Resident #18 was not wearing a device to secure his catheter tubing CNA #3 revealed that Resident #18 wears a catheter strap but it was removed during his shower and accidentally forgotten to be put back on CNA #3 further revealed that the Foley catheter bag should be hung below the resident's bladder to prevent Urinary Tract Infections. An interview on 03/29/17 at 11 25 AM, with CNA #4, confirmed she held the Foley catheter bag at	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 620	Continued From page 11 her waist which was above Resident #18's bladder. CNA #4 stated "I'm not suppose to lay it on the bed." CNA #4 was aware that placing the Foley catheter bag above the bladder could cause an infection to the bladder Interview on 03/30/17 at 12:05 PM, with Licensed Practical Nurse (LPN) #3, revealed that she provides in-services on Foley catheter/incontinent care Training included applying leg straps to secure the catheter. Review of the In-Service Training record, dated 09/26/16, revealed CNA #3 signed for being in attendance for catheter care training instructed by LPN #3. Review of the Face Sheet revealed the facility readmitted Resident #18 on 01/26/17, with diagnoses which included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. A review of the most recent MDS assessment with an ARD of 02/23/17, revealed Resident #18 scored 8 on the BIMS, which indicated moderate cognitive impairment.	M 620		
M 650	45.21 10 Hydration Hydration Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observation, record review, staff interview, and facility policy review, the facility failed to provide hydration measures to help	M 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 650	Continued From page 12	M 650		

prevent dehydration for Resident #14, for one (1) of 21 residents observed.

Findings include:

Review of the facility's "Hydration Policy" dated 01/15, revealed the facility will provide each resident with their required daily fluid intake needed to maintain adequate hydration. Each resident will have a pitcher of ice water freshened each shift, in their room and will be offered water by the staff during each round while the resident is awake and upon the resident's request.

Review of Resident #14's Physician's Orders revealed an order, dated 11/17/16, to encourage fluids.

Review of Resident #14's Dehydration care plan with an initial date of 05/25/15, and a revision date of 11/14/16, revealed interventions which included, encourage the resident to drink fluids of his choice, ensure the resident has access to cold water, and give extra fluids. The certified nurse aide (CNA) was listed on the care plan as the responsible discipline.

Observations on 3/27/17 at 2:00 PM, revealed Resident #14 had no water pitcher of ice/water in his room. Resident #14 stated that sometimes it took a few days for the staff to bring back his water pitcher when they took it up to wash.

Observations on 3/27/17 at 2:00 PM and 3:15 PM; 3/28/17 at 9.15 AM, 12:30 PM, and 4.05 PM; 3/29/17 at 8:45 AM, 11:50 AM and 3:55 PM, revealed Resident #14 had no water pitcher and ice in his room.

During an interview with Resident #14, on

M650

- Water pitcher was put into Resident #14's room immediately on 3/30/17.
- All residents have the potential to be affected by this deficient practice.
- All nursing staff was in-serviced on 3/30/17 on proper policy and procedures for cleaning, picking up, and replacing resident's water pitchers by the DON.
- Each unit manager will check water pitchers on a daily basis And bring the results to the DON on a monthly routine. The DON will bring the results to the QA committee for 90 days.
- Completion date 5/02/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 650	Continued From page 13 03/30/17 at 11:50 AM, he confirmed "I like to drink my water with ice. I want my water pitcher filled with ice and water. If I have bottled water then I pour it over in cup of ice from my water pitcher" During staff interview with the Director of Nursing (DON) and Staff Development Nurse, on 03/30/17 at 9:25 AM, confirmed the staff failed to provide hydration for Resident #14. The Staff Development Nurse said there was no reason why Resident #14 should not have had a water pitcher. The DON said the CNAs are responsible for making sure each resident has a filled water pitcher. During staff interview/observation of Resident #14's room, with Certified Nurse Aide (CNA) #6, on 03/30/17 at 11:50 AM, confirmed the resident did not have a water pitcher in his room. He said he worked with the resident during the 7:00 AM to 3:00 PM shifts on 03/27/17 through 3/29/17, and said he noticed the resident did not have a water pitcher, and said the resident did not mention not having a water pitcher. He said we offer the resident a water pitcher with ice but he sometimes refuses. During staff interview with CNA #1, on 03/29/17 at 3.30 PM, she confirmed the resident did not have a water pitcher in his room when she picked up the resident's water pitchers to take to the dietary department and have them swapped for clean (washed) water pitchers She said she worked with the resident on the 3.00 PM to 11:00 PM shift on 03/28/17 and 03/29/17, and was unaware of Resident #14 not having a water pitcher. Staff interview with RN/Charge Nurse #1, on 03/29/17 at 3.15 PM, revealed the water pitchers	M 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CC	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
M 650	Continued From page 14 are picked up from each resident's room on specified days and taken to the kitchen to have them washed. The dietary staff provides the CNAs with clean water pitchers to bring to the resident's room. The CNAs give the residents a pitcher with ice water, and the water pitchers are refilled on each shift. RN/Charge Nurse #1 said she was unaware of Resident #14 not having a water pitcher. Review of the facility's face sheet revealed, the facility admitted the resident on 05/25/15. Resident #14's diagnoses included Chronic Kidney Disease, Unspecified, and Acquired Absence of Unspecified Leg Above Knee. Review of the Minimum Data Set (MDS) with an Assessment Reference date of 02/08/2017, revealed Resident #14 had a Brief Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	M 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255282	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/30/2017

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
K 000	INITIAL COMMENTS	K 000		

42 CFR 438.70(a)

The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA)

There were no LSC deficiencies cited during this survey.

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

Administrator | 4-28-17

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.