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	255282	A. BUILDING _____ B. WING _____	03/30/2017

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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 Survey Agency (SA) conducted an annual recertification survey at the facility from 3/27/2017 - 3/30/2017. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F226, F246, F278, F280, F282, F285, F315, and F327. The facility census at the time of survey was 118 with a license for 121 beds.	F 000		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226	F226 • 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 date - 5-02-17	

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

Administrator — 4-28-17 Revised 5-4-17

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

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F 226	Continued From page 1 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: 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] 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	F 226		

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F 226	Continued From page 2 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."	F 226	F246 • 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	
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to provide a total lift sling required for transfers for			

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F 246	Continued From page 3 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 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,	F 246		

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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 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

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F 246	Continued From page 5 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.	F 246		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (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	F 278	• All resident's current MDS has been audited to assure that the MDS and pneumonia/ influenza administration was coded accurately per DON/ADON/ MDS on 4/3/17 • All residents have the potential to be affected by this deficient practice. • All MDS will be audited per MDS staff for accurately coding of pneumonia/influenza vaccine. • MDS staff were given in-service by the DON on 3/29/17 on policy and procedure of coding the Pneumonia/influenza vaccine on the MDS and the importance of accuracy of each resident's assessment. • Each MDS that is done will be audited for the pneumonia/influenza coding per MDS (RN/LPN) to assure that resident's coding for pneumonia/influenza vaccine matches their administration record. The MDS nurses will report findings to QA committee meeting monthly to ensure continued compliance. • Date of completion 5/02/17	

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F 278	Continued From page 6 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to Immunizations for two (2) of 24 records reviewed; Residents #12 and #17. Findings include. Review of the facility's "Minimum Data Set (MDS) Assessment" policy, dated 05/16, revealed the facility follows the Resident Assessment Instrument (RAI) process as set forth by the Centers for Medicare and Medicaid (CMS) protocol and will refer to the MDS RAI manual. Review of CMS's RAI Version 3.0 Manual revealed Coding instructions for O0250 would be to document whether or not the Influenza vaccine was administered to the resident and O0300 would be to document whether or not the Pneumatically Vaccine was up to date. Resident #12 A record review for Resident #12 revealed consent forms signed on 08/24/16, for the Influenza and Pneumonia vaccine to be administered Review of the Immunization Record and October 2016 Medication Administration Record (MAR), for Resident #12, revealed the Influenza and	F 278		

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F 278	Continued From page 7 Pneumonia vaccine were both administered on 10/04/16 A review of the most recent quarterly MDS assessment with an Assessment Reference Date (ARD) of 01/11/17, for Resident #12, revealed Section O0250 (Influenza Vaccine) and Section O0300 (Pneumatically Vaccine) were both checked as not received, due to being offered and declined Interview on 03/29/17 at 9:20 AM, with Registered Nurse (RN) #3, revealed she completed Section O250 and O300 on the quarterly MDS assessment dated 01/11/17 for Resident #12. RN #3 confirmed, upon review of the Immunization Record for Resident #12, that the MDS assessment was inaccurate. RN #3 revealed that she gets the information regarding vaccinations from the computerized Immunization record to complete Sections O250 and O300. RN #3 was unable to give reason as to why the MDS assessment was coded incorrectly An interview on 03/29/17 at 9.35 AM, with RN #2, confirmed, after reviewing Resident #12's Immunization records and quarterly MDS assessment, that Section 0250 and O300 was coded inaccurately. Review of the Face Sheet revealed the facility admitted Resident #12 on 04/20/16, with diagnoses which included Heart Failure, Anxiety, and Dementia A review of the quarterly MDS assessment with an ARD of 01/11/17, revealed Resident #12 scored 9 on the Brief Interview for Mental Status (BIMS), which indicated moderately impaired	F 278		

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F 278	Continued From page 8	F 278		

cognition.

Resident #17
Record review for Resident #17 revealed consent forms signed on 09/27/16, refusing the administration of the Influenza and Pneumonia vaccines.

Review of the Immunization record for Resident #17, revealed the family's refusal of administration of the Influenza and Pneumonia vaccine was confirmed on 10/06/16

Review of the most recent quarterly MDS assessment with an ARD of 02/02/17 for Resident #17, revealed Section O250 (Influenza Vaccine) was checked to indicate the vaccine was given on 10/04/16 Section O300 (Pneumatically Vaccine) was checked indicating the vaccine was up to date.

A review of Resident #17's MAR, for October 2016, revealed no documentation of an Influenza vaccination being administered.

Interview on 03/29/17 at 10:40 AM, with RN #3, revealed that Section 0250 and O300 was coded inaccurately upon comparing the quarterly MDS assessment with the Immunization record for Resident #17. RN #3 was not able to give a reason as to why the MDS assessment was coded inaccurately

A review of the Face Sheet revealed the facility admitted Resident #17 on 04/01/09, with diagnoses which included Other Specified Intracranial Injury without Loss of Consciousness, Anxiety and Hypertension

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F 278	Continued From page 9 Review of the quarterly MDS assessment with an ARD of 02/02/17, revealed Resident #17 was unable to complete the BIMS assessment. Per staff assessment, Resident #17 had severely impaired cognitive skills.	F 278	F280 • Resident's #2 care plan was updated on 4/3/17 by MDS RN All resident's care plan with foley catheter were audited and reviewed to reflect catheter care q day with soap and water and to provide peri-care. • All residents with catheters has the potential to be affected by this deficient practice. • MDS staff (RN/LPN) were given in-service by the DON on 03/29/17 on facility policies for care plan updates, of the regulatory requirements that the care-plans be current at all times and the importance of addressing foley catheter care and peri-care. • The MDS staff will audit any resident with catheter weekly x 3 months to ensure intervention for catheter car and peri-care is on the care-plan. MDS nurses will report findings to QA committee meeting monthly to ensure continued compliance. • Date of completion 5/2/2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or			

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F 280	Continued From page 10 resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s) An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 280		

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disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and facility policy review, the facility failed to revise the care plan related to catheter care for one (1) of 24 resident care plans reviewed; Resident # 2.

Findings include:

A review of the facility's "Care Plans-Comprehensive" policy, dated 10/16, revealed assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.

Resident #2
Review of Resident #2's care plan, initiated 3/6/16, related to the Foley catheter, revealed there was not an intervention in place to address Foley catheter care.

Interview on 3/29/17 at 3:55 PM with Registered Nurse (RN) #2 revealed "Well, we do provide the Certified Nursing Assistants (CNA) with catheter care training; and, I know that they (referring to the CNAs) have had some in-services." RN #2 stated "Catheter care usually involves cleaning with soap and water from top to bottom of the catheter tubing, holding the tubing while cleaning and I usually indicate that on the care plan. I don't know why I didn't on this one."

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F 280	Continued From page 12 Review of the Face Sheet revealed the facility admitted Resident #2 on 10/29/2016, with diagnoses which included Urinary Distention, Urinary Tract Infection and Fractured Femur 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	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review. the facility failed to follow the care plan related to catheter care for Resident #18; failed to obtain labs as ordered and provide proper hydration for Resident #14; for two (2) of 24 resident care plans reviewed Findings include. Review of the facility's "Care Plans-Comprehensive" policy, dated 10/16, revealed an individualized comprehensive care plan will be developed to include measurable objectives and timetables to meet the resident's	F 282 F282	• Resident # 18 foley catheter strap was replaced per nurse on 3/29/17. all residents with a foley catheter were checked for securing device placement per DON/nurse/can. .Resident # 14 labs were audited and reviewed on 3/29/17 per DON/unit manager/medical records. • All residents have the potential to be affected by this deficient practice. • CNA was given in-service by the DON on 3/29/17 on applying appropriate securing device to resident's with a foley catheter. Unit managers/LPN were given in-service by DON on 3/29/17on the policy and protocol for obtaining, reporting, and following up on lab orders for compliance. All staff was given in-service by DON on 3/29/17 on the importance of following the care plan. All Labs, residents on hydration. and catheter securing devices have been audited to ensure policy and care plans are being followed • Unit managers will monitor 1 resident with foley catheter, 2 x weekly x 3 months to ensure securing device for foley catheters are in place. The nurse will document on TAR q 2hours on catheter securing device. Unit managers/medical records nurses will monitor labs weekly to ensure labs are being obtained as ordered. DON will report findings to QA committee meeting monthly to ensure continued compliance • Date of completion 5/2/17	

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medical, nursing, mental and psychological needs. Each resident's care plan is designed to incorporate identified problem areas, risk factors associated with identified problems, identify the professional services that are responsible for each element of care, aid in preventing or reducing declines in the resident's functional status. Care plan interventions, when possible, address the underlying source(s) of the problem area(s) rather than addressing only symptoms or triggers.

Resident #14:
Review of Resident #14's care plan for risk of dehydration, revised on 11/14/16, revealed interventions to give extra fluids and ensure the resident has access to cold water.

Review of Resident #14's physician's orders revealed an order dated 11/17/16, to encourage fluids

Interview and observation on 3/27/17 at 2:00 PM, revealed Resident #14 had no water pitcher or fresh water and ice in his room. Resident #14 stated that it took a few days for him to get his water pitcher back after staff take it up to wash it

Observations on 3/27/17, 3/28/17 and 3/29/17 revealed there was no water pitcher or ice in Resident #14's room

During staff interview with Licensed Practical Nurse #1, on 03/30/17 at 10.10 AM, confirmed Resident #14's care plan was not followed because staff did not provide a water pitcher and fluids for the resident.

Review of Resident #14's care plan for risk of

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bleeding related to Coumadin and Plavix use, with an initial date of 11/14/15, and revision date of 2/8/17, revealed interventions that included obtain labs as ordered and report the findings to the resident's physician.

Review of Resident #14's Physician's Orders, revealed an order dated 04/01/16, to obtain a Prothrombin/International Normalized Ratio (PT/INR) monthly.

Record review of Resident #14's medical records, revealed there were no PT/INR results for the month of 01/17.

Staff interview with RN #2, on 03/29/17 at 3 40 PM, confirmed the staff failed to follow the care plan related to anticoagulation therapy, and the physician's order to obtain (PT/INR). She confirmed the 01/17 PT/INR labs were not collected.

Review of the facility's face sheet revealed, the facility admitted Resident #14 with an admission date of 05/25/15. Resident #14's diagnoses include 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.

Resident #18
Review of the care plan for Resident #18, revised on 2/1/17, revealed a problem to address the use of an indwelling Foley catheter related to

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F 282	Continued From page 15 diagnoses of Urinary Retention and Benign Prostatic Hyperplasia. Interventions included leg straps to secure the catheter and to position the catheter bag and tubing below the level of the bladder. 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. CNA #4 held the Foley catheter bag at her waist level, above the resident's bladder, while CNA #3 cleaned the resident's buttocks. Upon completion of the catheter care, CNA #3 did not apply a device to secure the catheter tubing. Interview on 3/30/17 at 12.05 PM, with Licensed Practical Nurse (LPN) #3, revealed she is the Staff Development Nurse and provides training to staff on Foley catheter care Upon review of Resident #18's care plan, LPN #3 confirmed the care plan was not followed A 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 Review of the most recent MDS with an ARD of 02/23/17, revealed Resident #18 scored 8 on the BIMS assessment, which indicated moderate cognitive impairment	F 282		
F 285 SS=D	483 20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination	F 285		

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A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with·

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and

(B) If the individual requires such level of

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- Resident that was missing PASSARR had one done on 4/21/17
- All Residents have potential to be affected by this deficient practice
- Admission Coordinator and Business Office Manger was in-serviced by the Administrator on 4/21/2017 that all future admissions should have PASSAR done at time of admission.
- Administrator will monitor admissions on a weekly basis for 90-days and report all findings to the QA Committee for a 3 months.
- Completion date – 05/02/17

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F 285	Continued From page 17 services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F 285		

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(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1)

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483 102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to complete a Pre-Admission Screening (PAS) timely for one (1) of 24 resident records reviewed [Resident #6].

Findings include

The facility did not have a policy and procedure for Pre-Admission Screening, per documented letterhead dated 3/27/17, and signed by the Admissions person

Review of the facility's face sheet revealed, the

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F 285	Continued From page 19 facility admitted Resident #6 on 12/31/16. Resident #6's diagnoses included Status Post Fracture Left Femur, Osteoarthritis, Cerebral Infarction, Irritable Bowel Syndrome, Status Post Pneumonia and Glaucoma. There was no documented PAS in the resident's clinical record On 3/27/17 at 1:55 PM, an interview with Admissions person revealed she did the Pre-Admission Screenings before the admission if the diagnosis was Mental Retardation and if the resident was short term care, she did it after they were in the building. The Admissions person couldn't say why Resident #6 didn't have a PAS completed. She stated that Resident #6 was admitted short term and, "I should have done it after 30 days." Review of the 60 day Minimum Data Set (MDS) with an Assessment Reference Date(ARD) of 2/27/17, revealed Resident #6 had a Brief Interview of Mental Status (BIMS) score of 12, indicating the resident had moderately impaired cognition	F 285		
F 315 SS=E	483 25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		

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(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

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(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, record 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

- 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

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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 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

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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 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

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F 315	Continued From page 23 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.	F 315		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to provide hydration measures to help prevent dehydration for Resident #14, for one (1) of 21 residents observed Findings include.	F327	• 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	

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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 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

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 _____	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
F 327	Continued From page 25	F 327		

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 are picked up from each resident's room on specified days and taken to the kitchen to have

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	255282	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) COMPLETION DATE
F 327	Continued From page 26	F 327		

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.

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 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.	K 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.