

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

PRINTED: 02/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255192</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CLAIBORNE COUNTY SENIOR CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2124 OLD HWY 61 SOUTH<br/>PORT GIBSON, MS 39150</b>                          |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 884<br>SS=F                                                           | <p>Reporting - National Health Safety Network<br/>CFR(s): 483.80(g)(1)(i)-(ix)(2)</p> <p>§483.80(g) COVID-19 reporting. The facility must--</p> <p>§483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to—</p> <p>(i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19;</p> <p>(ii) Total deaths and COVID-19 deaths among residents and staff;</p> <p>(iii) Personal protective equipment and hand hygiene supplies in the facility;</p> <p>(iv) Ventilator capacity and supplies in the facility;</p> <p>(v) Resident beds and census;</p> <p>(vi) Access to COVID-19 testing while the resident is in the facility;</p> <p>(vii) Staffing shortages; and</p> <p>(viii) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and</p> <p>(ix) Therapeutics administered to residents for treatment of COVID-19.</p> <p>§483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public.</p> | F 884                                                                      |                                                                                                                          | 1/30/23                    |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/30/2023

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 884                                                                   | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation.</p> <p>The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 01/23/2023 and 01/29/2023, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.</p> | F 884                                                                      |                                                                                                                          |                            |                                                        |