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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare LLC - Snf	1251 Pinehaven Road Clinton, MS 39056

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observations, interviews, record reviews and policy reviews, the facility failed to provide wound care in a manner to prevent the possibility of wound infection for two (2) of (2) wound care observations. Resident #1 and Resident #4 Findings Include: A record review of the facility's policy titled Wound Care dated 1/2015 revealed Policy: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Procedure: .After cleaning the wound as ordered, clean the tissue around the wound . On 4/10/25 at 11:12 AM during an observation of wound care for Resident #1 by Licensed Practical Nurse (LPN) # 1/Wound Care Nurse and assisted by Certified Nursing Assistant (CNA) #1 revealed LPN #1 cleaned the stage IV pressure injury wound bed from the outer edge toward the inner aspect in a circular motion. She dried wound site with gauze from the outer edge toward the inner wound bed in a circular motion four times and applied clean dressing. On 4/10/25 at 1:55 PM in an observation of wound care for Resident #4 completed by LPN #1 and assisted by CNA #2 revealed LPN#1 cleaned wounds from the outer edge toward the inner aspect three times each in a circular motion. She discarded gauze and used a clean gauze and dried the wound from the outer edge towards the inner area of the wound bed. On 4/10/25 at 2:23 PM in an interview with LPN #1 confirmed that she did not clean Resident #1 and Resident #4 wounds correctly. She stated she should clean the inside and move outer to prevent contaminating the wound. She stated Resident #1 and #4's wounds can get infected by the way she cleaned the wounds. On 4/10/25 at 4:52 PM in an interview with Registered Nurse #1 (RN)/ Infection Preventionist Nurse stated LPN #1 should have cleaned the wound from inner to outer to prevent possibly infecting the wounds. She stated LPN #1 contaminated the wounds. On 4/10/25 at 5:31 PM in an interview with the Director of Nursing (DON) stated LPN #1 should clean from inner to outer and dispose of gauze. She stated LPN #1 could possibly spread infection. Resident #1: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission record revealed admitted : 06/12/24. Diagnoses: Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia. A record review of Resident #1 Order Summary Report revealed an order dated 4/8/25 Cleanse stage IV pressure injury to sacrum with Dakins Solution, pat dry. Apply collagen then hydrofera blue and secure with silicone foam dressing every other day and as needed. A record review of Resident #1 Minimum Data Set (MDS) with Assessment Reference Date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident had moderate cognitive impairment. Resident #4: Record review of the admission record revealed an admitted [DATE] with diagnoses of Essential Hypertension and Type 2 Diabetes Mellitus without complications. Record review of the Order Summary Report for Resident #4 revealed an order dated 4/4/25 Cleanse with Dakin's solution, pat dry. Apply Mupirocin to wound bed and cover with alginate and silicone sacral border dressing daily and prn (as needed), one time a day related to Pressure Ulcer of Sacral Region, Stage 3. Record review of the MDS with ARD: 03/5/25 revealed BIMS score 99 indicating the resident was unable to complete the interview.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to provide wound care and incontinent care in a manner to prevent the possibility of spreading infection by not wearing a gown for Enhanced Barrier Precautions (EBP) during wound care and failing to perform proper hand hygiene during incontinent care. This deficient practice was observed for two (2) of two (2) residents reviewed for infection control practices (Resident #1 and Resident #4). Findings include: A record review of the facility's Infection Prevention and Control Program policy dated 8/2017, revealed It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 4 .b. Staff shall wash their hands before and after performing resident care procedures A record review of the facility's policy Enhanced Barrier Precautions, undated, revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown, and gloves use during high contact resident care activities. On 04/10/25 at 11:12 AM, during an observation of wound care for Resident #1 provided by Licensed Practical Nurse (LPN) #1 (Wound Care Nurse), assisted by Certified Nursing Assistant (CNA) #1, revealed they did not follow Enhanced Barrier Precautions. LPN #1 performed wound care without a gown, and CNA #1 assisted by turning Resident #1 without wearing a gown. On 04/10/25 at 2:18 PM, in an interview, CNA #1 stated it slipped her mind to put on a gown while assisting LPN #1 with wound care. She stated she should have applied a gown to protect the wound and acknowledged prior training on Enhanced Barrier Precautions. On 04/10/25 at 2:08 PM, during an observation of incontinent care for Resident #4 provided by CNA #2, she exited the room wearing a gown from prior wound care, removed it in the hallway, and returned to the room with supplies. She did not wash hands or don a new gown but applied gloves and began peri care. Resident #4 had feces in the brief. CNA removed soiled gloves three times but did not perform hand hygiene between glove changes. She continued to provide care, pulling wipes from the package with soiled gloves. CNA #2 finished care, removed gloves, and washed hands before exiting the room. On 04/10/25 at 2:23 PM, in an interview, LPN #1 stated she forgot to wear a gown during Resident #1's wound care. On 04/10/25 at 2:41 PM, in an interview, CNA #2 stated she should have worn a gown and washed her hands before and during care. She confirmed that she used soiled gloves to handle wipes and acknowledged the resident could get an infection from the care provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/25 at 4:52 PM, in an interview, Registered Nurse (RN) 1 (Infection Prevention Nurse) she confirmed that LPN #1, CNA #1 and CNA #2 should have worn gowns before starting care, placing the residents at risk of infection and potential spread to others. She also stated CNA #2 failed to follow proper hand hygiene during incontinent care. The last EBP training was conducted in January 2025. On 04/10/25 at 5:31 PM, in an interview, the Director of Nursing (DON) stated LPN #1, and the CNAs should have applied gowns prior to care, and that when residents are on EBP, extra precautions are required. She acknowledged possible infection spread due to improper gown use and hand hygiene lapses. Resident #1: Record review of the admission record revealed admitted : 06/12/24. Diagnoses: Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia. A record review of Resident #1 Order Summary Report revealed an order dated 4/8/25 Cleanse stage IV pressure injury to sacrum with Dakins Solution, pat dry. Apply collagen then hydrofera blue and secure with silicone foam dressing every other day and as needed. A record review of Resident #1 Minimum Dat Set (MDS) with Assessment Reference Date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident had moderate cognitive impairment. Resident #4: Record review of the admission record revealed an admitted [DATE] with diagnoses of Essential Hypertension and Type 2 Diabetes Mellitus without complications. Record review of the Order Summary Report for Resident #4 revealed an order dated 4/4/25 Cleanse with Dakin's solution, pat dry. Apply Mupirocin to wound bed and cover with alginate and silicone sacral border dressing daily and prn (as needed), one time a day related to Pressure Ulcer of Sacral Region, Stage 3. Record review of the MDS with ARD: 03/5/25 revealed BIMS score 99 indicating the resident was unable to complete the interview.