

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Clinton Healthcare LLC - Snf		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>48669</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to reasonable accommodation of needs regarding a call light for one (1) of 24 sampled residents. Resident #39.</p> <p>Findings Include:</p> <p>Review of the facility's booklet, A Matter of Rights: A Guide to Your Rights and Responsibilities as a Resident that is provided to residents upon admission, page four (4) revealed, Dignity and Respect . This includes the right .to expect care and a residential setting that .promotes your quality of life .reflects your individual needs and preferences .</p> <p>During an observation and interview, Resident #39 was observed lying on her side in bed on 6/11/24, at 9:10 AM, with the call light attached to her blanket just below her hands. The resident mentioned she frequently finds it difficult to get staff members to check on her. She admitted that she cannot operate her call light because the right and left fingers of her hands are contracted. The call light was observed to be a standard call light in which a button must be pressed for the light to activate and indicate assistance was required by the resident.</p> <p>On 6/12/24 at 12:28 PM, in an interview with Resident # 39, she reiterated her inability to use the call light due to her contracted hands. She shared her usual method of seeking assistance involved waiting for someone to pass by and calling out for help. She expressed her dissatisfaction with the situation and stated that she had learned to accept it as the norm.</p> <p>On 6/12/24 at 1:19 PM, in an interview with Certified Nursing Assistant #2 (CNA), she acknowledged the resident's inability to use her call light due to her contracted hands. CNA #2 explained rounds were completed every two hours and if the resident required immediate assistance, the resident could call out to any staff member passing by the door for help.</p> <p>In an interview with the Director of Nursing (DON) on 6/12/24 at 4:04 PM, she disclosed that the call light served as a means for residents to alert staff members when they required assistance. The DON explained the type of call light required for a resident was determined at the time of admission for each resident. The DON stated the facility typically offered residents a pancake light (a type of call light for residents with limited mobility) who might have problems utilizing the standard call light. She explained that if Resident #39 could not activate the call light, it could keep her from getting the care she needed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/24 at 4:33 PM, during a follow-up interview in the resident's room with the DON, she confirmed Resident #39 had contracted hands which prevented her from using her present call light. She stated she would get the resident a more functional call light, such as a pancake light, because it would allow the resident to alert staff members by touching the light instead of pressing a button.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #39 on 9/20/2021 with current diagnoses including Contracture of Muscle, left Upper Arm, Contracture, Left Hand, and Muscle Weakness.</p> <p>A record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/11/24 revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>41680</p> <p>Based on observation, interviews, record review, and the facility policy review, the facility failed to ensure a residents' right to privacy by posting a sign regarding resident's care in view, above the bed for one (1) of 24 sampled residents. Resident #28.</p> <p>Findings include:</p> <p>A review of the facility's policy Resident's Rights dated 4/2012 revealed, . Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . d. Privacy and confidentiality .</p> <p>On 06/11/24 at 10:35 AM, in an observation, Resident #28 was lying in bed and there was a sign above the bed which indicated, *Aspiration Risk* Please ensure pt (patient) is pulled up in bed and head is raised for all Meals- Speech therapy. Resident #28 reported he was not aware of the signage on the wall.</p> <p>On 06/12/24 at 5:00 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed Resident #28 had a sign in view above his bed with private information regarding aspiration precautions. LPN #2 was unsure how long the sign had been on the resident's wall.</p> <p>On 06/13/23 at 11:05 AM, during an interview with the Speech Therapist (ST), she confirmed she placed the sign above Resident#28's bed regarding aspiration precautions. She explained she had educated the staff on how to position the resident for meals and then placed the sign. The ST reported she was informed by the Administrator the signs could not stay up due to privacy and she stated she would no longer place signs in view in resident's rooms.</p> <p>On 06/13/24 at 02:21 PM, during an interview with the Administrator and the Director of Nursing (DON), the Administrator reported she was made aware yesterday there was signage in view in Resident #28's room. She confirmed information posted did not honor the resident's right to privacy and both she and the DON reported they expected the facility staff to always respect the privacy and dignity of all residents.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #28 on 04/13/23 and he had current diagnoses including Dysphagia.</p> <p>Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/12/24, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated moderate cognitive impairment.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41680</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure an enteral feeding pump was operated by licensed staff for two (2) of three (3) residents observed with Percutaneous Endoscopic Gastrostomy (PEG) tube feedings. (Resident #47 and Resident #93)</p> <p>Findings Include:</p> <p>Review of the facility's policy, Enteral Pump Alarm revised 1/2015, revealed It is the policy of this facility for enteral pumps to only be turned off and on by a licensed nurse. This procedure should never be delegated to assistive personnel .Procedure .Only licensed nurses will control the operations of the enteral feeding pump .</p> <p>Resident #47</p> <p>During an observation, on 6/11/24 at 2:11 PM, Certified Nurse Aide (CNA) #1 entered Resident #47's room to provide incontinent care. CNA #1 turned off the resident's enteral feeding pump. After the incontinent care was completed, CNA #1 turned the enteral feeding pump back on.</p> <p>During an interview on 6/12/24 at 3:00 PM with CNA #1, she confirmed she had turned the enteral feeding pump off and back on. She explained she was nervous and was not thinking at the time. CNA #1 stated she should have asked the nurse to turn the pump off and back on and she was aware nurses were responsible for operating the feeding pumps.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #47 on 6/18/21 with diagnoses including Dysphagia.</p> <p>Resident #93</p> <p>During an observation on 6/12/24 at 3:15 PM, CNA #3 and CNA #4 began providing incontinent care for Resident #93. The enteral feeding for Resident #93 was on hold prior to entry into the room. During the care, the enteral feeding pump began beeping. CNA #4 instructed CNA #3 to press the hold button to stop the beeping. CNA #3 pushed the hold button on the enteral feeding pump to silence the beeping. As the CNAs continued the care, the enteral feeding pump began beeping again and CNA #3 pressed the hold button on the feeding pump again. After incontinence care was completed, CNA #3 pressed the button to restart the enteral feeding.</p> <p>On 06 12/24 at 4:08 PM, in an interview with CNA #3, she confirmed she had operated the enteral feeding pump several times during care by placing it on hold and turning it back on after incontinence care was completed. She stated she should not have touched the feeding pump and should have let the nurse operate it.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #93 on 10/13/23 with current diagnoses including Dysphagia.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>43283</p> <p>Based on interviews, record review, and facility policy review, the facility failed to ensure a resident was free from unnecessary medication by continuing an as needed (PRN) psychotropic medication past a 14-day duration for one (1) of six (6) residents sampled for unnecessary medications. Resident #55</p> <p>Findings include:</p> <p>A review of the facility's policy Monitoring of Antipsychotic Medication Therapy, revised 06/2015 revealed . It is the policy of this facility to monitor the effectiveness and side effects for any resident that is taking an antipsychotic medication. Procedure .5. The Pharmacy consultant will review these meds (medications) monthly and make dose reduction recommendations as indicated per CMS (Center for Medicare and Medicaid Services) guidelines .</p> <p>A record review of the Order Summary Report with active orders as of 4/30/2024, revealed Resident #55 had a Physician's Order, dated 4/18/24 for Amitriptyline HCL (Brand name of Elavil and classified as a psychotropic medication) 25 milligrams (mg), one (1) tablet by mouth every 24 hours as needed for depression at bedtime. There was no stop date indicated on the Physician's Order.</p> <p>A record review of the May 2024 Interdisciplinary Psych Dashboard revealed Resident #55 had a medication of Elavil 25 mg PRN and included the Pharmacist Comments of PRN Psychotropic orders must have a 14 day stop order and patient must be evaluated by physician prior to continuing. The IDT (Interdisciplinary Team) responded, Current Medication Regime appears appropriate and agreeable at this time unless otherwise noted.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #55 on 01/11/17 with diagnoses including Other Recurrent Depressive Disorders.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/24, Section N . Medications .High-Risk Drug Classes: . revealed Resident #55 was code as taking an antidepressant.</p> <p>On 06/13/24 at 11:39 AM, during a phone interview with Nurse Practitioner, she explained she was aware PRN psychotropic medications needed a new order after 14 days.</p> <p>On 06/13/24 at 2:26 PM, during an interview with the Administrator and Director of Nursing (DON), both reported they expected staff to follow the federal guidelines regarding a 14-day duration for PRN psychotropic medications.</p>		