

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/20/2025
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview, record review and policy review the facility failed to have an Advance Directive readily available for staff usage if needed for one (1) of twenty-three (23) resident Advance Directives reviewed. Resident #83 Findings include: A record review of the facility policy, Residents Rights Regarding Treatments and Advance Directive, no date, revealed, Policy: It is the resident's right to formulate an Advance Directive, and to accept to refuse or accept medical or surgical treatment. Procedure. 1. On admission, the facility will determine if the resident has formulated an Advance Directive .On 11/18/25 at 12:25 PM in an interview with License Practical Nurse #2 (LPN) who works in Medical Records confirmed that the advance directive was not in the paper chart. She stated the purpose of having it in the chart is if the resident is unable to cognitively respond it should be in the chart so staff can have access. In an interview with the Director of Nursing (DON) on 11/20/25 at 1:15 PM, stated that Advance Directives are important to have to direct the healthcare of a resident according to his or her wishes. If they are not addressed, a resident could end up receiving more aggressive care than they really want or not receiving the care that they would have wished to have when a certain situation arises and they become incapacitated. A record review of Resident #83's admission Record revealed the facility admitted Resident 83 on 10/10/25 with diagnoses including Other Pulmonary Embolism without Acute Cor Pulmonale and Essential (Primary) Hypertension. A record review of Resident #83's electronic chart revealed it does not contain Advance Directive. A record review of the paper chart revealed it does not contain the Advance Directive. On 11/18/25 at 12:18 PM in an observation of DON reviewing the chart for Advance Directive she confirmed it was not in the paper chart. A record review of Resident #83's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.		

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and facility policy review, the facility failed to implement its abuse-prevention policy by not completing a written investigation when staff were made aware of suspected physical abuse for one (1) of 21 sampled residents (Resident #106). Findings include: A review of the facility's Abuse Policy Employee Responsibility dated 3/21/23, revealed, .5. The facility will identify and INVESTIGATE all suspicions or allegations of abuse. a. the facility will thoroughly INVESTIGATE all alleged violations under the direct supervision of the Administrator. 7. Any alleged incident REPORTED must be investigated. A review of the facility's Abuse Investigation Process, dated 3/21/23, revealed, The investigation will include the following: a. Written report from the person reporting the incident with date of report and date and time of incident (Incident/Accident Report). d. Signed statements from all witnesses, stating time, date and shift of incident. Documentation of investigation should include: A description of resident's behavior and environment at the time of the incident, injuries present, observation of resident staff's behavior during the investigation. On 11/17/25 at 2:52 PM, during an observation and interview, Resident #106 was seated in a wheelchair with her sister present. The sister stated she had concerns related to care. She stated that on 11/10/25 at 1:48 PM, she found the resident crying and the resident said someone had pushed her and had been mean to her. She stated she contacted the Director of Nursing (DON), who questioned the resident; the resident responded yes when asked if someone had pushed her. She stated the DON and two staff conducted a body audit. She stated the DON placed an intervention requiring a nurse to be present during care. On 11/19/25 at 9:48 AM, during an interview with the DON, she stated Resident #106's sister had reported concerns on 11/10/25 that a staff member was mean and had shoved the resident. She stated the resident is difficult to interview because she will respond yes to all questions. She confirmed a full body audit was completed and there were no signs of injury, and the resident was questioned. The DON reported that she did not document the investigation and confirmed the facility's policy required a written investigation and she did not follow policy. On 11/19/25 at 10:45 AM, during an interview with the Administrator, she stated all nurses can complete an incident report. She stated she was aware of the allegation but did not instruct staff to complete a written incident report. On 11/19/25 at 3:52 PM, during a follow up interview with the Administrator, she confirmed all allegations of abuse must be addressed. She stated she had reviewed policy and regulations but also used common sense and felt no further action was necessary because the resident could not communicate clearly. A record review of the admission Record revealed the facility admitted Resident #106 on 9/17/21 with a diagnosis including Aphasia Following Cerebral Infarction. A record review of Resident #106's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed staff assessment for mental status was modified independence - some difficulty in new situations only.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments for one (1) of twenty-three (23) residents reviewed for assessment accuracy (Resident #40). This is evidenced by the facility incorrectly coding the resident as receiving anticoagulant therapy on two consecutive MDS submissions. Findings include: A review of the MDS Assessment Policy, dated 5/2006, reveals, It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol. A record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/25 and 10/9/25 reveals a yes indicating the resident is on an anticoagulant. A record review of the physician orders does not reveal Resident #40 received anticoagulant medication. At 11/18/25 at 10:39 AM, in an interview with Licensed Practical Nurse #1 (LPN) who is the MDS Nurse, confirmed that she did code the annual MDS with Assessment Reference Date (ARD) of 7/11/25 and the quarterly MDS with ARD of 10/9/25 wrong and that it was an oversight on her part. She said it is important to ensure accuracy of the coding so that everything about the resident is captured and that the facility uses that information to get paid. On 11/20/25 at 12:36 PM, in an interview with the Director of Nursing (DON), she explained that the MDS informs the facility of the needs of the resident such as the type of care, interventions, diets, fall risk and medication plans. Therefore, ensuring its accuracy is crucial since it's how the facility tailors and delivers the right care for each resident. A record review of the admission Record revealed the facility admitted Resident #40 on 7/15/24 with a diagnosis including Unspecified Congestive Heart Failure.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure oxygen-use cautionary signage was posted on or near the resident's door for one (1) of one (1) resident reviewed for respiratory care, Resident #78. Findings included: A review of the facility's policy, Oxygen Safety, revealed, 'No Smoking' signs must be clearly visible in areas where oxygen is stored or in use. On 11/17/25 at 11:48 AM, during an observation, Resident #78 was lying in bed and receiving oxygen via a nasal cannula at two (2) liters per minute. There was no Oxygen in Use sign posted on or near the resident's door. On 11/17/25 at 11:50 AM, during an observation and interview, Registered Nurse (RN) #1 came to the doorway of Resident #78's room and confirmed the absence of cautionary oxygen signage. RN #1 stated that a sign had previously been present and must have fallen off. RN #1 acknowledged that clearly posted signage is necessary for safety. On 11/20/25 at 2:00 PM, during an interview with the Director of Nursing (DON), she stated that oxygen is a highly flammable gas and confirmed that signage identifying oxygen use is necessary to ensure resident and staff safety. A record review of the admission Record revealed the facility admitted Resident #78 on 7/31/25 with diagnoses including Shortness of Breath. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/25 revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Further review revealed he received Oxygen therapy within the last 14-day lookback period. A record review of the Order Summary Report revealed Resident #78 had a Physician's Order, dated 9/9/25 for Oxygen at two (2) liters via nasal cannula every shift.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection control guidelines when a Certified Nursing Assistant (CNA) provided catheter care while wearing false fingernails that interfered with glove use and effective hand hygiene for one (1) of four (4) care observations, Resident #5. Findings included: A review of the facility's Hand Hygiene policy, dated 7/1/24, revealed, .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors .A review of the facility's Dress Code (undated), revealed, .Long nails should not be worn. Nails should be no longer than the tip of the finger. Fingernails should always be kept clean. On 11/19/25 at 10:39 AM, during an observation of catheter care for Resident #5, Certified Nursing Assistant (CNA) #1 was observed wearing artificial fingernails approximately two (2) inches beyond the fingertips. She had difficulty placing gloves over the nails, requiring four glove changes during the procedure. Each time gloves were changed, she used hand sanitizer but did not clean underneath the long artificial nails. On 11/19/25 at 10:55 AM, during an interview with CNA #1, she stated that her fingernails were fake and acknowledged that they were very long, causing difficulty when putting on gloves during care. She stated the facility had instructed CNAs during monthly in-service training not to wear long or artificial nails because they can spread infection and may scratch or injure residents. On 11/19/25 at 3:35 PM, during an interview with the Director of Nursing (DON), she stated that staff nails should be kept neatly trimmed per facility policy to prevent the spread of infection caused by bacteria that can live under long or artificial fingernails. On 11/20/25 at 11:00 AM, during an interview with the Infection Preventionist (IP) Nurse, he stated that the facility policy recommends nails be kept no longer than the fingertip. He explained that long nails can harbor bacteria, are difficult to clean under, and can contribute to the spread of infection. A record review of Resident #5's admission Record revealed the facility admitted the resident on 8/11/23 with diagnoses including Encephalopathy. A record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.		