STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255101	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McComb Nursing and Rehabilitation Center LLC	415 Marion Ave McComb, MS 39648

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interviews, record review, and facility policy review, the facility failed to implement care plan intervention related to activities of daily living (ADL) care and hydration for one (1) of four (4) sampled residents, Resident #1. Findings Included: Review of the facility's policy, Care Plans, dated 1/15, revealed, .Each resident will have a plan of care to identify problems, needs and strengths that will identify how the team will provide care Record review of the Admission Record revealed the facility admitted Resident #1 on 2/22/24 with current diagnoses including [NAME] Obstructive Pulmonary Disease (COPD). Record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she had moderate cognitive impairment. Further review revealed Resident #1 was dependent upon staff for ADL care. Record review of the Order Summary Report for Resident #1 revealed the resident had physician order listed as Increase water intake by mouth eight ounces three times daily in between meals three times a day with Start Date 8/01/24. Record review of the current Care Plan for Resident #1 revealed the resident had a 'Focus' listed as has the potential for constipation with 'Interventions' listed as 'Encourage adequate fluid intake'; she had a 'Focus' listed as 'has the potential for complications/fluid volume imbalance' with 'Interventions' listed as 'Encourage adequate fluid intake. Fluids with meals/meds, per hydration cart, and at request'; the resident had 'Focus' listed as 'has a self- care deficit due to impaired mobility' with 'Interventions' listed as 'assist with ADLs (activities of daily living) as indicated .nail care to be performed by nursing .one person assistance with eating .hygiene'. On 4/07/25 at 12:15 PM, an observation revealed Resident #1 had no water, water pitcher or water glass in their room. There was an unopened eight (8) ounce bottle of water and a half-filled gallon labeled water on the top of the resident's chest of drawers, out of reach of the resident. Resident #1 had ten (10) fingernails with a thick, grayish brown substance beneath each nail. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/07/25 at 12:22 PM, during an observation, the Medical Records Nurse entered the room and offered to assist Resident #1 with lunch and assisted her to drink the water in her glass. The resident's lunch tray was removed, including fluids from the room. There was no water or fluids, or container left for the resident. On 4/07/25 at 1:25 PM, an interview with the Administrator revealed she was aware that Resident #1 had bottled water in her room out of her reach and no water glass or pitcher. On 4/07/25 at 2:05 PM, an observation revealed Resident #1 did not have any water, glass or pitcher in reach. On 4/07/25 at 2:06 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she said the staff took ice and water to residents. She reported that fluids for oral intake (PO fluids) were provided on meal trays, with medication administration and in Styrofoam cups for all residents unless contraindicated by the resident's condition based on physician orders and resident's care plan. She confirmed that the nurses were responsible for the supervision of care for assigned residents and the implementation of care plan interventions. She stated that Resident #1 received oral (PO) fluids with her breakfast tray, she was not sure how much of those were consumed. She confirmed that the resident received PO fluid with administration of medications and that Resident #1 did not have water provided during the morning of 4/07/25. She stated, We dropped the ball there with the water. She said she believed that ice and water were to be provided at 10:00 AM and 2:00 PM. She confirmed that she had not provided any other PO fluids for Resident #1 on 4/07/25 and she was not sure of the amount of PO fluids consumed by Resident #1 on 4/07/25, she stated, I can't say, I didn't give her any before lunch. On 4/07/25 at 2:30 PM, an observation revealed Resident did not have any water, glass or pitcher in reach and Certified Nurse's Aide (CNA) #1 brought a Styrofoam cup of ice water with straw to Resident #1. On 4/07/25 at 3:00 PM an interview with the Director of Nurses (DON) revealed she said that making sure residents were well hydrated was important and that she expected resident care plans to be followed because it was very important to implement interventions which were in place to address issues the residents had. She said that all nurses had access to resident care plans and all CNAs had access to resident care instructions in each resident's Kardex, which had interventions pulled from the residents' care plans. On 4/07/25 at 4:30 PM an interview with the Administrator revealed she stated that implementation of residents' care plans was very important to ensure appropriate care was provided for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interviews, record reviews, and facility policy review, the facility failed to provide activities of daily living (ADL) care, specifically nail care, for a dependent resident for one (1) of four (4) sampled residents, Resident #1. Findings Included: Review of the facility's policy titled, A.M. Care, dated 10/09, revealed, .A.M. (Morning) Care will be given to residents daily .Procedure .10. Provide nail care as needed . Record review of the Admission Record revealed the facility admitted Resident #1 on 2/22/24 with current diagnoses including [NAME] Obstructive Pulmonary Disease (COPD).a Record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she had moderate cognitive impairment. Further review revealed Resident #1 was dependent upon staff for ADL care. On 4/07/25 at 12:15 PM, an observation revealed Resident #1 had ten fingernails with thick grayish brown substance beneath each nail. On 4/07/25 at 2:30 PM, during an observation and interview, Licensed Practical Nurse (LPN) #1 reviewed the fingernails of Resident #1 and described them as dirty and removed chunks of a grayish brown substance from beneath each of the resident's fingernails with an orange stick. Resident #1 indicated she preferred her fingernails to be their length, but did not like them to be dirty. On 4/07/25 at 3:00 PM, an interview with the Director of Nurses (DON) revealed she expected staff to perform resident nail care for residents. On 4/07/25 at 4:00 PM an interview with CNA #3 revealed that personal hygiene, including fingernail care and grooming was to be provided to all residents each shift as needed. On 4/07/25 at 4:30 PM an interview with the Administrator revealed it was very important to ensure appropriate care was provided for each resident including grooming, including fingernail care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interviews, record review, and facility policy review, the facility failed to provide hydration care and services to one (1) of four (4) sampled residents, Resident #1. Findings Included: Policy review of the facility policy titled 'Water Pitchers/Water Glasses' with review date 10/09 revealed the policy stated, Each resident will be provided with ice water/tap water at the bedside .Responsibility Nursing Assistants. Record review of the Admission Record revealed the facility admitted Resident #1 on 2/22/24 with current diagnoses including [NAME] Obstructive Pulmonary Disease (COPD). Record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she had moderate cognitive impairment. Further review revealed Resident #1 was dependent upon staff for ADL care. Record review of the Order Summary Report for Resident #1 revealed the resident had physician order listed as Increase water intake by mouth eight ounces three times daily in between meals three times a day with Start Date 8/01/24. During an observation on 4/07/25 at 12:15 PM, Resident #1 had no water, water pitcher or water glass in their room. There was an unopened eight (8) ounce bottle of water and a half filled gallon labeled water on the top of the resident's chest of drawers, out of reach of the resident. During an observation on 4/07/25 at 12:22 PM, the Medical Records Nurse, entered the room and offered to feed the resident lunch, and assisted the resident to drink the water in her glass. The resident's lunch tray was removed, including fluids from the room, leaving no water or fluids or container left for the resident. The resident consumed all the water in the glass. During an interview on 4/07/25 at 1:20 PM, the Director of Nursing (DON) stated that unless clinically contraindicated, all residents should have fresh water available at all times. During an interview on 4/07/25 at 1:25 PM, the Administrator revealed that she was aware that Resident #1 had bottled water in her room that was out of her reach and had no water glass or pitcher. During an observation on 4/07/25 at 2:05 PM, Resident #1 did not have any water, glass or pitcher in reach. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/07/25 at 2:06 PM, Licensed Practical Nurse (LPN) #1 revealed she said the staff took ice and water to residents. She reported that fluids for oral intake (PO fluids) were provided on meal trays, with medication administration and in Styrofoam cups for all residents unless contraindicated by the resident's condition based on physician orders. She confirmed that the nurses were responsible for the supervision of care for assigned residents and the implementation of care planned interventions. She stated that Resident #1 received PO fluids with her breakfast tray, she was not sure how much of those were consumed. She confirmed that the resident received PO fluid with administration of medications and that Resident #1 had not had water provided during the morning of 4/07/25. She stated, We dropped the ball there with the water. She said she believed that ice and water was to be provided at 10:00 AM and 2:00 PM. She confirmed that she had not provided any other PO fluids for Resident #1 on 4/07/25 and she was not of the mouth of PO fluids consumed by Resident #1 on 4/07/25, she stated, I can't say, I didn't give her any before lunch. During an interview on 4/07/25 at 3:00 PM, the DON revealed she said that making sure residents were well hydrated was important and that she expected resident care plans to be followed because it was very important to implement interventions which were in place to address issues the residents had. She said that all nurses had access to resident care plans and all CNAs had access to resident care instructions in each resident's Kardex, which had interventions pulled from the residents' care plans. During an interview on 4/07/25 at 4:00 PM, CNA #3 revealed that it was her understanding that fresh water was to be provided to all residents unless contraindicated at least one time each shift. During an interview on 4/07/25 at 4:30 PM, the Administrator revealed she stated that it was very important to ensure appropriate care was provided for each resident. She confirmed that providing and offering water for all residents was very important and that the facility provided ice and Styrofoam cups and straws for the disbursement of water to all residents for which there was no contraindications.