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	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McComb Community Care Center	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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and interviews the facility failed to provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to a resident requiring such care or initiate the emergency response system in accordance with related physician's orders and the resident's advance directives for one (1) of four (4) sampled residents. Resident #1 The facility's failure to review and implement the code status according to the advance directives resulted in Resident #1 not receiving CPR and emergency services. The resident subsequently expired at the facility. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on [DATE] and existed at: 42 CFR(s): 483.24 (a)(3) -Cardiopulmonary Resuscitation (F678) Scope and Severity J.This situation placed Resident #1 and all other residents who were full code status at risk for serious injury, serious harm, serious impairment, or death.The SA notified the facility's Administrator of the IJ and SQC on [DATE] at 1:45 PM and provided the IJ template. The facility provided an acceptable corrective action plan on [DATE] in which they alleged all corrective actions to remove the IJ were completed on [DATE] and the IJ removed on [DATE].Based on the facility's implementation of corrective actions on [DATE], the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on [DATE] prior to the SA's entrance on [DATE]. Findings Included:Record review of the facility policy titled, Emergency Procedure-Cardiopulmonary Resuscitation version date [DATE], revealed, . If an individual (resident, visitor or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or b. There are obvious signs of irreversible death (e.g., rigor mortis) .Emergency Procedure-. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing.b. Instruct a staff member to activate the emergency response system (code) and call 911.c. Verify or instruct a staff member to verify the DNR or code status of the individual. d. Initiate the basic life support (BLS) sequence of events.chest compressions, airway, breathing.Record review of the RESIDENT/FAMILY CONSENT FOR CARDIOPULMONARY RESUSCITATION dated [DATE] for Resident #1 and signed by Resident #1's Resident Representative (RR) revealed the document indicated by initials of the RR stated, I understand that CPR constitutes an extraordinary measure and SHOULD be done on this resident in care of extreme emergency. Record review of the Progress Notes for Resident #1 dated [DATE] at 5:47 AM, revealed Licensed Practical Nurse (LPN) #1 documented on [DATE] she observed the resident was not breathing and she was unable to obtain any vital signs and documented that in response she notified a hospice nurse, the resident's primary healthcare provider and Resident Representative (RR), the Director of Nurses (DON) and the Executive Director (ED), with no mention of initiation of cardiopulmonary resuscitation.Record review of the incident Report dated [DATE] revealed that on [DATE], Resident was found unresponsive at approximately 5:20 am by the CNA. The CNA reported to the nurse resident condition. The nurse went to the Resident room and found the resident in his bed unresponsive. She attempted to obtain a pulse and (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	blood pressure without success and did not observe any rise or fall of his chest.Record review of the Facility Investigation revealed LPN #1 observed Resident #1 was not responsive at 5:20 AM on [DATE] and did not verify the resident's code status and did not initiate the emergency response system or CPR. On [DATE] at 1:20 PM, during a telephone interview LPN #1 revealed that at approximately 5:20 AM on [DATE] she observed Resident #1 was not responsive. She said she left his room, gathered equipment to measure vital signs, returned and was unable to attain any detectable pulse and Resident #1 had no chest rise or fall and she was unable to auscultate any breath sounds with stethoscope. She stated that she left him again and grabbed his binder at the nurses' station to locate the telephone number for his hospice service and notified the on-call hospice nurse that he had died. She stated that she was notified by the DON on [DATE] that Resident #1 had a code status of Full Code. LPN #1 stated, I didn't run a code due to him being hospice. I always worked with hospice patients that were DNR code status. She confirmed that when she grabbed the resident's binder (or chart) she did not look for his code status. She confirmed that she did not look on Point Click Care (PCC) software for the resident's code status and that she got his binder (chart) to look for the telephone number for his hospice service.On [DATE] at 1:25 PM, during an interview the ED said she was notified on [DATE] by the night shift (11:00 PM to 7:00 AM) Nurse Supervisor of an allegation that proper emergency procedure for an unresponsive resident was not initiated when Resident #1 was determined to be unresponsive by LPN #1 on [DATE]. She confirmed that she notified the DON of the allegation on [DATE] at 7:28 AM. She said an investigation was immediately initiated, beginning with record review of the medical record for Resident #1 and subsequent interview with LPN #1. The ED confirmed that the facility investigation determined that LPN #1 had failed to follow the correct protocol for an incidence of an unresponsive resident on [DATE] because she failed to check Resident #1's code status after determining he was nonresponsive and pulseless and failed to initiate the proper emergency procedure for an unresponsive resident. She confirmed that facility policy was that any incident of a resident being nonresponsive should result in their nurse checking, or having another staff check, the resident's code status. She confirmed that failure to check a resident's code status and that failure to initiate the emergency CPR procedure for a resident with ?Full Code' code status during an unresponsive episode could result in lack of provision of potentially lifesaving interventions. On [DATE] at 1:30 PM, during an interview the Director of Admissions revealed each resident's code status was printed on the admission Record (the first item in each resident's binder/chart) and under the Advanced Directives tab behind the admission Record. She said there would also be a Physician's Order if the resident requested DNR. She confirmed the code status was visible on each resident's Electronic Medication Administration Record (EMAR) available to nurses. She stated that just because the resident received hospice services did not mean they automatically had a DNR code status.Record review of the Order Summary Report revealed an order dated [DATE] for code status Full Code, which indicated the resident had chosen to receive cardiopulmonary resuscitation in case of cardiac arrest or pulselessness.Record review of a handwritten Physician's Telephone Orders dated [DATE] revealed an order to admit to hospice with a code status listed as Full Code.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on [DATE] with diagnoses of severe protein-calorie malnutrition, heart failure and atherosclerotic heart disease.Record review of the Minimum Data Set (MDS) for Resident #1 with Assessment Reference Date (ARD) [DATE] revealed the resident's Brief interview for Mental Status (BIMS) score was listed as 99 with documentation that the resident was unable to complete the interview, with no noted memory problem and was independent with decisions regarding tasks of daily life. Section 0 of the MDS review revealed the resident received hospice care.Corrective Action PlanResident (#1) who was receiving hospice services from Hospice Compassus beginning on [DATE], for unspecified severe protein calorie malnutrition, unspecified systolic congestive heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, personal history of malignant neoplasm of the prostate, and dysphasia unspecified. Resident has resided at (continued on next page)

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