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	09/13/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 48669 Based on observation, interviews, and record reviews, the facility failed to provide the resident or the Resident Representative (RR) with written notification of the bed-hold policy at the time of transfer for one (1) of one (1) sampled residents reviewed for hospitalization . Resident #18. Findings Include: Record review of a typed statement on facility letterhead, dated September 13, 2024, and signed by the Administrator revealed, (Proper name of facility) does not have a policy regarding bed holds. On 09/13/24 at 8:16 AM, during an interview with the RR for Resident #18, he stated that he did not receive a call from the Business Office Manager (BOM) or anyone from the facility regarding his father's bed hold for the hospital transfer that occurred on 09/10/24. The RR explained that no written notification or information was provided about the bed-hold process On 09/13/24 at 8:36 AM, during an interview with the BOM she revealed that she does not send out a bed-hold letter to families when residents are transferred to the hospital. She explained that residents and their families are given the bed-hold information upon admission to the facility. She stated that after each hospital transfer, she typically calls the family to notify them about the bed hold. When the State Agency (SA) requested a copy of the documented bed-hold notification in her system as proof of RR notification for Resident #18, the BOM admitted that she had not placed a note in the system. She also confirmed that she does not document bed-hold notifications in the system for any residents. On 09/13/24 at 11:02 AM, during an interview with the Administrator, she explained that the facility's procedure for notifying families of bed holds occurs upon admission. She stated that she was unaware that the facility was required to provide bed-hold notification at each hospital transfer. The Administrator acknowledged that the facility did not have a policy regarding bed-hold notifications for hospital transfers. A record review of the After Visit Summary revealed that Resident #18 was transferred to the hospital on 09/10/24 and returned to the facility on [DATE]. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Admission Record revealed that the facility admitted Resident #18 on 01/10/2022 with diagnoses that included Atrial Fibrillation and Heart Failure. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed that Resident #18 had a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
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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. 47873 Based on staff interviews, record reviews, and facility policy review, the facility failed to implement the care plan interventions as reflected in the resident's comprehensive Care Plan related to a fall for one (1) of twenty-three (23) sampled residents. Resident #37. Findings Include: A review of the facility's policy titled Comprehensive Person Centered Care Plans, (D.3) dated 3/18, revealed, Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care .Definitions . Comprehensive Person Centered Care Plan (CCP) - contains services provided, preference, ability, goals for admission and desired outcomes, and care level guidelines .Procedure: .4. The Interdisciplinary Team along with the resident and /or Resident Representative will identify resident problems, needs, strengths, life history, preferences, and goals . A record review of Resident #37's care plan with a start date of 5/7/2024 revealed (Proper name of Resident #37) has the potential for falls .Intervention: Dycem to w/c (wheelchair) . A record review of Resident #37's care plan with a start date of 5/7/2024 revealed (Proper name of Resident #37) has a self care deficit .Intervention: Dycem to w/c . During an interview on 09/12/24 at 9:13 AM, Certified Nursing Assistant (CNA) #1 stated that she had not witnessed any falls during the day shift but recalled receiving a report of a fall approximately two weeks ago. She confirmed that there was not a Dycem non-slip mat in the Resident #37's wheelchair. On 09/12/24 at 9:15 AM, during an interview and observation with Licensed Practical Nurse (LPN) #3, she explained that the staff assisted the resident whenever she called and routinely asked if she needed to be repositioned, even when performing other tasks in the room. She emphasized reminding the resident to use the call light and avoid getting up without assistance. LPN #3 confirmed that there was not a Dycem nonslip mat in the resident's wheelchair. During an interview on 09/12/24 at 9:40 AM, with the Speech Therapist (ST), Director of the Therapy Department, she explained that they held weekly Interdisciplinary Team (IDT) fall meetings to review falls, assess previous interventions, and analyze the circumstances leading to each fall. She remarked, You can't stop a fall, but the purpose of these interventions is to minimize the risk and keep residents safe. The ST emphasized that failing to follow recommendations could compromise both resident and staff safety. On 09/13/24 at 9:14 AM, Resident #37 was observed asleep in her bed, with her wheelchair positioned at the bedside. There was not a non-slip mat (Dycem) noted in the resident's wheelchair as indicated as an intervention on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #37's Order Summary Report with active orders as of 9/13/24, revealed an order dated 8/20/24 Skilled Physical Therapy four (4) times a week for six (6) weeks, including therapeutic exercise, therapeutic activities, neuromuscular reeducation, gait training, moderate complexity evaluation, electrical stimulation, ultrasound, and short-wave diathermy for diagnoses of Muscle Weakness (M62.81) and Difficulty Walking (R26.2). A record review of Resident #37's Admission Record revealed the facility admitted the resident on 5/27/24 with diagnoses that included Unspecified Dementia, with other behavioral disturbance and Other symptoms and signs involving the musculoskeletal system. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/24, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Review of Section J revealed that the resident had experienced two (2) or more fall since admission without injury.

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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. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to provide timely incontinence care and oral care for one (1) of four (4) residents reviewed for activities of daily living (ADL) care. Resident #73 Findings Include: A review of the facility's policy titled A.M. Care, dated 10/09, revealed: Policy: A.M. Care will be given to residents daily. Responsibility: All Nursing Assistants . On 09/09/24 at 11:48 AM, during an interview, the Resident Representative (RR) of Resident #73 stated that the Certified Nursing Assistants (CNAs) did not regularly brush her daughter's teeth or wash her hair. She explained that her daughter was unable to perform personal care independently and could not feed herself. The RR expressed her wish was that staff would more consistently perform these tasks. On 09/09/24 at 11:52 AM, an observation revealed Resident #73's RR brushing and flossing the resident's teeth. The resident's hair appeared short and oily. On 09/12/24 at 2:39 PM, during an interview, CNA #4 stated that ADL care, which includes perineal care, tooth cleaning, and hair care, is performed daily. She explained that if residents refuse care, the refusal is documented in the CNA book, and occasionally the nurse is notified. On 09/13/24 at 9:52 AM, during an observation and interview with Licensed Practical Nurse (LPN) #6, the Unit Manager, he explained that ADL care includes cleaning the face and brushing the teeth and should be completed before breakfast. He noted that Resident #73's hair was oily and could benefit from a wash. He emphasized that he expects CNAs to provide total ADL care. On 09/13/24 at 10:07 AM, during an interview, CNA #1 stated that she washed Resident #73's face before breakfast and would perform peri-care once the resident got up. She initially stated that she had completed all ADL care for Resident #73 but later admitted that she had not brushed the resident's teeth or washed her hair that day or week. She confirmed that both tasks should have been completed. On 09/13/24 at 1:15 PM, during an interview, the Director of Nursing (DON) confirmed that ADL care includes brushing teeth and washing hair as needed. She emphasized that CNAs are responsible for ensuring that residents' nails are clean and that all aspects of ADL care are performed. A record review of Resident #73's Admission Record revealed that the facility admitted the resident on 7/28/22 with diagnoses that included Hemiplegia, Unspecified Affecting the Left Non-Dominant Side and Unspecified Intellectual Disabilities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/29/24 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 99, indicated the resident could not participate in the interview. Section GG of the MDS revealed that Resident #73 is dependent on staff for oral hygiene, showering, and hair care. 47873 48669

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41680 Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to provide urinary catheter care in a manner that prevents possible complications for one (1) of one (1) residents reviewed for urinary catheter care. Resident #18. Findings Include: A review of the facility's policy titled Catheter Care, dated 5/22, revealed, Catheter care is performed to keep the catheter insertion site clean .3. Cleanse around the area where the catheter enters the urethral meatus with an incontinent wipe in a downward motion about 4 inches . Discard soiled incontinent wipes and plastic bag appropriately. On 09/09/24 at 02:38 PM, during an observation and interview, it was noted that Resident #18 had a urinary catheter. The resident was unable to recall how long he had a urinary catheter, however, he stated that it had been for some time. A record review of Order Summary Report, with active orders as of 9/13/24, revealed Resident #18 had a physician order, dated 8/15/24, for urinary catheter and another order, with the same order date, for urinary catheter care every twelve (12) hours as needed. On 09/13/24 at 10:25 AM, during an observation of perineal care, including urinary catheter care provided for Resident #18 by Certified Nursing Assistant (CNA) #2, revealed CNA #2 used the same area of the wipe with each stroke while cleaning the resident's penis. Rather than cleaning the resident's penis with a downward stroke, CNA #2 wiped from bottom to top. CNA #2 then cleaned the urinary catheter tubing, using a back to forth motion, once again using the same area of a single wipe. On 09/13/24 at 10:53 AM, during an interview, CNA #2 admitted that he should have used a clean wipe for each stroke and cleaned from the top to bottom, while providing perineal care to Resident #18. He acknowledged that his care could possibly cause complications. On 09/13/24 at 11:14 AM, during an interview, Licensed Practical Nurse (LPN) #5, the Infection Preventionist, confirmed that CNA #2 should have used downward strokes while cleaning the resident and used clean wipes with each stroke. She emphasized that improper cleaning could lead to complications. On 09/13/24 at 1:07 PM, during an interview, the Director of Nurses (DON) stated that she expected CNA #2 to perform care correctly, as taught during in-service training. She explained that going from a dirty area to a clean area could possibly result in the resident developing a urinary tract infection (UTI) or skin irritation. A record review of Resident #18's Admission Record revealed that the facility admitted the resident on 1/10/22, The resident's diagnoses included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Retention of Urine, and Urinary Tract Infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #18's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact. 47873

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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. 41680 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide respiratory care in a manner to prevent the possibility of complications as evidenced by oxygen tubing that was not dated to indicate weekly oxygen tubing/nasal cannula changes and not cleaning the oxygen concentrator filter as required for one (1) of one (1) resident reviewed for respiratory care. Resident #26 Findings Include: A review of the facility's policy titled Oxygen Therapy, dated 8/14 revealed, Oxygen (O2) is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress .Procedure: . 8. Change tubing weekly. 9. Date tube when changed (weekly). On 9/9/24 at 10:30 AM, during an observation of Resident #26, who was sitting in her wheelchair in her room with a nasal cannula in her nose, it was noted that the oxygen tubing was not dated. On 9/9/24 at 10:35 AM, during an observation and interview with the Director of Nursing (DON), she explained that staff should write the date on a clear plastic bag when the tubing is changed weekly. Upon inspection of the bedside table, the DON pulled out two clear plastic bags, neither of which were dated. She confirmed that the bags should have been dated and that staff are expected to check the tubing and when not in use, store it in a clear plastic bag, which should be changed weekly to maintain infection control. She added that she expects staff to clean the filter when they change the tubing. On 9/9/24 at 10:40 AM, during an interview with Licensed Practical Nurse (LPN) #4, she stated that oxygen tubing is changed weekly for infection control purposes and should be dated when changed. On 9/9/24 at 12:55 PM, during an interview and observation with LPN #4, the oxygen concentrator filter for Resident #26 was found to have a moderate amount of grey lint along the edges and support grid. LPN #4 confirmed that the filter should have been cleaned when the tubing was changed. She acknowledged that the filter had not been cleaned, citing the amount of lint as evidence. She emphasized that cleaning the filter is necessary to ensure the resident receives clean air. On 9/12/24 at 3:39 PM, during an interview with LPN #5, the Infection Preventionist (IP), he stated that the oxygen tubing is supposed to be changed weekly to prevent the buildup of bacteria and reduce the risk of respiratory infections for the resident. On 9/13/24 at 9:56 AM, during an interview with LPN #6, Unit One Nurse Manager, he confirmed that oxygen tubing should be changed every Saturday night and dated to verify it had been changed. He explained that the tubing is replaced to protect the resident from infection and that the oxygen concentrator filter should also be cleaned at the same time, as it filters the air. A record review of Resident #26's Admission Record revealed the facility admitted the resident on 2/9/24. The resident's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia, and Dependence on Supplemental Oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Order Summary report, with active order as of 9/1/24 revealed Resident #26 had a physician order, dated 2/9/24, to change the oxygen tubing and clean the oxygen filter every Saturday night. A record review of Resident #26's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/29/24 revealed a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact. Section O indicated that the resident was receiving oxygen therapy. 47873

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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. 41680 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure proper hand hygiene and enhanced barrier precautions were followed prior to providing care for a resident with an indwelling catheter, for one (1) of one (1) resident observed for urinary catheter care. Resident #18. Findings Include: A review of the facility's policy titled Enhanced Barrier Precautions (EBP), dated 4/24, revealed . Definition: 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in Nursing Homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (e.g. residents with wounds or indwelling medical devices) A review of the facility's policy titled Catheter Care, dated 5/22 revealed, Catheter care is performed to keep the catheter insertion site clean .Procedure: 1. Complete perineal care. 2. Wash hands and apply gloves . A review of the facility's Hand Washing policy, dated 9/19, revealed Staff are expected to use proper handwashing techniques to prevent the spread of infection . On 9/9/24 at 2:38 PM, prior to entering the room on Resident #18, signage of resident's door was observed. The sign indicated that the resident was on Enhanced Barrier Precautions and stated that everyone entering the resident's room must clean their hands when entering and leaving the room. Further information intended for staff directed staff performing high-contact resident care activities to wear gloves and a gown. Upon entering the room, it was noted that Resident #18 had an indwelling urinary catheter. On 09/13/24 at 10:25 AM, during an observation of care provided by Certified Nursing Aide(CNA) #2, entered Resident #18's room without performing hand hygiene. Prior to beginning perineal care, CNA #2 applied gloves, however, CNA#2 did not put on a gown. During the procedure, CNA #2 did not remove his soiled gloves to open the drawer to the bedside table to retrieve additional supplies. At one point, CNA #3, who was assisting CNA #2, reminded CNA #2 to remove his gloves prior to opening the resident's closet door to retrieve a clean brief for the resident. CNA #2 removed his gloves, but failed to perform hand hygiene prior to applying clean gloves. On 09/13/24 at 10:53 AM, during an interview, CNA #2 admitted that he forgot to wear a gown and should have washed his hands prior to beginning care and after each glove change. He acknowledged that failing to wash his hands could increase the risk of infection to the resident. On 09/13/24 at 11:14 AM, during an interview, Licensed Practical Nurse (LPN) #5, the Infection Preventionist, confirmed CNA #2 failed to follow proper hand hygiene protocols. She emphasized that the CNA's failure to wear a gown and perform hand hygiene increased the risk of infection for Resident #18. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/13/24 at 1:07 PM, during an interview, the DON, also reiterated that by CNA #2 not wearing a gown and his lack of hand hygiene could increase the risk of infection for Resident #18, as well other residents receiving care provided by the CNA. A record review of Resident #18's Admission Record revealed that the facility admitted the resident on 1/10/22, The resident's diagnoses included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Retention of Urine, and Urinary Tract Infection. A record review of Resident #18's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.