STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255352	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comfort Care Nursing Center	1100 West Drive Laurel, MS 39440

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, record review, and facility policy review, the facility failed to notify the physician and the resident's representative of the initiation of psychosocial services for (3) of (3) sampled residents receiving individual psychosocial therapy, Residents #4, #5, and #6, with the potential to affect all 21 residents receiving psychosocial therapy. Specifically, the facility failed to ensure that the physician and resident representative (RR) were informed when 1:1 psychosocial therapy services were initiated by a third-party provider. Findings Included: A review of the facility's Resident Rights Notification of Changes Policy, reviewed date 05/30/2025 revealed, It is the policy of (Proper Name of Facility) to notify the resident; consult with the physician; and notify, consistent with his or her authority, the resident representative of changes as discussed in the policy . On 6/11/25 at 11:00 AM, a phone interview with the complainant revealed that there is a Licensed Certified Social Worker (LCSW) that is not employed by the nursing home facility (3rd Party Provider) who comes to the facility to provide psychosocial therapy to several residents. The complainant stated that LCSW refuses to share the names of the residents she provides services to, which prevents the facility from notifying the residents' Responsible Representatives (RRs) and the physician of new treatments or interventions. The complainant expressed concern that when the physician is not notified, there is no opportunity to review, approve, or coordinate the therapy with the resident's overall medical plan of care. This could result in duplicate or conflicting treatments, overlooked medication considerations, or a missed opportunity to address any underlying conditions. Additionally, the complainant was concerned that failure to notify the RR limits their ability to monitor the resident's care and make informed decisions on their behalf and advocate effectively for the resident's needs, especially if the resident has limited insight. On 6/12/25 at 10:00 AM, in an interview with the facility's Social Services staff member, she confirmed that the LCSW is from the local hospital and enters the facility on Thursdays to provide therapy on residents within the facility. She does not inform the facility's staff, Psychiatric Nurse Practitioner (NP), or the physician who she is providing therapy for. Therefore the facility is unable to notify the RR of any new orders or treatments of her services. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25 at 10:30 AM, in an interview, the LCSW confirmed that she has provided the behavioral services to approximately 21 residents at the facility. She revealed that the residents are self-referrals, and they all have a Brief Interview for Mental Status (BIMS) score of 13 or greater. The LCSW stated that she does not provide any information regarding these residents to the nursing staff or the facility, because it is confidential. On 6/12/25 at 10:45 PM, during an interview, Registered Nurse (RN) #1 stated that she was not aware of which residents were receiving psychosocial therapy services from the LCSW in the facility. She confirmed that, as a result, no physician orders had been obtained for the service, and the facility had not notified the residents' RRs of the initiation of therapy. RN #1 acknowledged that the facility has a written policy requiring physician involvement and RR notification prior to any changes in treatment and confirmed that this policy had not been followed for residents receiving psychosocial services from the LCSW. On 6/12/25 at 11:10 AM, during an interview, the Administrator confirmed that the LCSW was providing psychosocial therapy services to residents within the facility. The Administrator stated that all referrals were initiated by the residents themselves. He acknowledged that the facility did not follow its policy requiring RR and physician notification. On 6/12/25 at 1:27 PM, during an interview, the Nurse Practitioner/Psych confirmed that she was not aware that the LCSW evaluated or performed sessions with Resident #4, #5, and #6. She explained there was no referral provided to the facility on which residents the LCSW was providing treatment. On 6/12/25 at 1:45 PM, during an interview with the Physician, he confirmed that he was not aware of and had not issued any referrals for Residents #4, #5, or #6 to receive psychosocial evaluations or treatment. A record review of the facility's statement, dated 6/12/25, and signed by the Administrator revealed, The facility did not have a referral for (Proper Name of LCSW), no care plan, and no notification of resident representative . regarding Resident #4, Resident #5, and Resident #6. A record review of the LCSW resident service list revealed that she had provided psychosocial services to 21 residents, including Resident #4, Resident #5, and Resident #6. A record review of the medical records for Resident #4, Resident #5, and Resident #6 revealed there were no documentation indicating the RRs or they physician's were notified regarding behavioral therapy received by the residents. Resident #4 A record review of the admission Record revealed the facility admitted Resident #4 on 4/18/24 with current diagnoses including Fibromyalgia. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review of Section D and Section E indicated there were no behaviors exhibited by the resident and there were no mood symptoms present. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Resident #4 received Cognitive Behavioral Therapy weekly and bi-weekly as needed on the following dates: December 5, 2024, December 12, 2024, December 19, 2024, January 9, 2025, January 16, 2025, January 22, 2025, January 30, 2025, February 20, 2025, February 27, 2025, March 6, 2025, and March 19, 2025 for Major Depressive Disorder. Patient declined visits on February 6, 2025 and February 13, 2025. Resident #5 A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Sacral Spina Bifida without Hydrocephalus. A record review of Optional MDS with an ARD of 5/13/25, revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Further review of Section D and Section E revealed there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided once a month to Resident #5 on December 19, 2024, January 9, 2025, February 6, 2025, March 6, 2025 and May 29, 2025 for Depression. Patient declined April 2025 visit. Patient discharged from services on May 29, 2025, due to completion of treatment plan. Resident #6 A record review of the admission Record revealed the facility admitted Resident #6 on 12/15/23 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Optional MDS with an ARD of 4/15/25 revealed Resident #6 had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of Section D and Section E revealed the resident did not exhibit any behaviors or there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided bi-weekly to Resident #6 on January 16, 2025, January 22, 2025, February 6, 2025, February 20, 2025, March 6, 2025, and March 20, 2025 and May 29, 2025 for Depression . Patient declined visits from April 3, 2025-May 29, 2025. Patient continues to be seen bi-weekly in accordance with treatment plan.

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(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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview, and facility policy review, the facility failed to develop a comprehensive care plan that included all services provided to address the psychosocial needs of three (3) of three (3) sampled residents receiving individual psychosocial therapy (Residents #4, #5, and #6), with the potential to affect all 21 residents receiving psychosocial therapy. Specifically, the facility failed to include ongoing psychosocial therapy services provided by the Licensed Clinical Social Worker (LCSW) in the residents care plans to ensure coordination of care, consistent monitoring, and individualized interventions based on the residents' psychosocial needs. Findings included: A review of the facility's Comprehensive Person-Centered Care Plan Policy, reviewed on 1/24/2024, revealed, .It is the policy of this facility to develop and implement a comprehensive person-centered plan of care for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . During a phone interview on 6/11/25 at 11:00 AM, the complainant revealed that there are no care plans related to behavioral therapy received by residents seen at the facility by a LCSW. She explained the LCSW is not employed by the nursing home facility (3rd Party Provider) and she refuses to share any information regarding the residents to which she provides services. On 6/12/2025 at 10:00 AM, during an interview with the facility's Social Services Director, she confirmed there are no behavioral care plan interventions that includes the services provided by the LCSW that visits the facility. On 6/12/2025 at 10:30 AM, during an interview with the LCSW, she confirmed that she has seen approximately 21 residents in the facility, and she does not provide the name of the residents or any information to the facility due to confidentiality. On 6/12/2025 at 10:45 AM, during an interview with Registered Nurse (RN) #1, she stated that there was no documentation or Physician's Orders provided to the facility by the LCSW and as a result, care plans were not developed for residents receiving behavioral therapy. On 6/12/2025 at 11:00 AM, during an interview with Licensed Practical Nurse (LPN)/MDS Coordinator #1, she confirmed that Residents #4, #5, and #6 did not have care plans reflecting services provided by the LCSW. She stated that comprehensive care plans are important to ensure residents receive individualized care. She further stated that although Section D of the MDS captured mood concerns on occasion, these were not cross-referenced with therapy services provided by the LCSW, since the facility was not informed of the sessions. On 6/12/2025 at 11:30 AM, during an interview with the Assistant Director of Nursing (ADON), she confirmed that all services provided to residents, including psychosocial therapy, should be incorporated into the resident's care plan. She stated the LCSW has refused to collaborate with the team or provide documentation, which prevented the facility from creating care plans reflecting these services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25 at 11:45 AM, during an interview with the Administrator, he confirmed there is no indication that the interdisciplinary team was involved in developing or reviewing care plans related to psychosocial therapy services provided by the LCSW. A record review of the facility's statement, dated 6/12/25, and signed by the Administrator revealed, The facility did not have a referral for (Proper Name of LCSW), no care plan, and no notification of resident representative . regarding Resident #4, Resident #5, and Resident #6. A record review of the LCSW resident service list revealed that she had provided psychosocial services to 21 residents, including Resident #4, Resident #5, and Resident #6. A record review of the medical records for Resident #4, Resident #5, and Resident #6 revealed there were no care plan interventions developed reflecting behavioral therapy received by the residents from the LCSW. Resident #4 A record review of the admission Record revealed the facility admitted Resident #4 on 4/18/24 with current diagnoses including Fibromyalgia. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review of Section D and Section E indicated there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Resident #4 received Cognitive Behavioral Therapy weekly and bi-weekly as needed on the following dates: December 5, 2024, December 12, 2024, December 19, 2024, January 9, 2025, January 16, 2025, January 22, 2025, January 30, 2025, February 20, 2025, February 27, 2025, March 6, 2025, and March 19, 2025 for Major Depressive Disorder. Patient declined visits on February 6, 2025 and February 13, 2025. Resident #5 A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Sacral Spina Bifida without Hydrocephalus. A record review of Optional MDS with an ARD of 5/13/25, revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Further review of Section D and Section E revealed there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided once a month to Resident #5 on December 19, 2024, January 9, 2025, February 6, 2025, March 6, 2025 and May 29, 2025 for Depression. Patient declined April 2025 visit. Patient discharged from services on May 29, 2025, due to completion of treatment plan. Resident #6 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the admission Record revealed the facility admitted Resident #6 on 12/15/23 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Optional MDS with an ARD of 4/15/25 revealed Resident #6 had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of Section D and Section E revealed the resident did not exhibit any behaviors or there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided bi-weekly to Resident #6 on January 16, 2025, January 22, 2025, February 6, 2025, February 20, 2025, March 6, 2025, and March 20, 2025 and May 29, 2025 for Depression. Patient declined visits from April 3, 2025-May 29, 2025. Patient continues to be seen bi-weekly in accordance with treatment plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, interview, and facility policy review, the facility failed to ensure services were provided and documented according to professional standards for (3) of (3) sampled residents receiving individual psychosocial therapy, Residents #4, #5, #6, with the potential to affect all 21 residents receiving psychosocial therapy. Specifically, the facility failed to obtain a physician's order for ongoing psychosocial therapy services provided by a third party Licensed Clinical Social Worker (LCSW), resulting in services being delivered without appropriate physician oversight. Findings included: A review of the facility policy titled, Physician Orders, reviewed 01/24/2024, revealed, .Scope: Physician's orders that will be obtained, noted, and implemented appropriately . During a phone interview on 6/11/25 at 11:00 AM, the complainant revealed that there are no Physician's Orders for residents who are seen at the facility by a LCSW for behavioral therapy. She explained the LCSW is not employed by the nursing home facility (3rd Party Provider) and she refuses to share the names of the residents to which she provides services. During an interview on 6/12/2025 at 10:00 AM, the facility's Social Services Director confirmed there were no Physician's Orders for behavioral therapy services that are provided to the residents by the visiting LCSW. During an interview on 6/12/2025 at 10:30 AM, the LCSW confirmed she does not provide resident names to the facility due to confidentiality nor provides them with any documentation of her sessions with the residents. She stated she has seen approximately 21 residents in the facility. On 6/12/2025 at 10:45 AM, during an interview with Registered Nurse (RN) #1, she confirmed there are no Physician's Orders for the residents who are seen by the LCSW regarding behavioral services. On 6/12/2025 at 11:30 AM, during an interview with the Assistant Director of Nursing (A-DON), she confirmed that all services provided to residents, including psychosocial therapy, should have a Physician's Order. On 6/12/25 at 1:45 PM, during an interview with the Physician, he confirmed there were no orders or referrals for Resident #4, #5, and #6 and without physician orders, the facility was unable to ensure that services provided by the LCSW were appropriate to the resident's diagnoses or current mental health status. A record review of the facility's statement, dated 6/12/25, and signed by the Administrator revealed, The facility did not have a referral for (Proper Name of LCSW), no care plan, and no notification of resident representative . regarding Resident #4, Resident #5, and Resident #6. A record review of the LCSW resident service list revealed that she had provided psychosocial services to 21 residents, including Resident #4, Resident #5, and Resident #6. A record review of the medical records for Resident #4, Resident #5, and Resident #6 revealed there were no Physician's Orders initiated reflecting behavioral therapy received by the residents. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 A record review of the admission Record revealed the facility admitted Resident #4 on 4/18/24 with current diagnoses including Fibromyalgia. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review of Section D and Section E indicated there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Resident #4 received Cognitive Behavioral Therapy weekly and bi-weekly as needed on the following dates: December 5, 2024, December 12, 2024, December 19, 2024, January 9, 2025, January 16, 2025, January 22, 2025, January 30, 2025, February 20, 2025, February 27, 2025, March 6, 2025, and March 19, 2025 for Major Depressive Disorder. Patient declined visits on February 6, 2025 and February 13, 2025. Resident #5 A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Sacral Spina Bifida without Hydrocephalus. A record review of Optional MDS with an ARD of 5/13/25, revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Further review of Section D and Section E revealed there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided once a month to Resident #5 on December 19, 2024, January 9, 2025, February 6, 2025, March 6, 2025 and May 29, 2025 for Depression. Patient declined April 2025 visit. Patient discharged from services on May 29, 2025, due to completion of treatment plan. Resident #6 A record review of the admission Record revealed the facility admitted Resident #6 on 12/15/23 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Optional MDS with an ARD of 4/15/25 revealed Resident #6 had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of Section D and Section E revealed the resident did not exhibit any behaviors or there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided bi-weekly to Resident #6 on January 16, 2025, January 22, 2025, February 6, 2025, February 20, 2025, March 6, 2025, and March 20, 2025 and May 29, 2025 for Depression. Patient declined visits from April 3, 2025-May 29, 2025. Patient continues to be seen bi-weekly in accordance with treatment plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record review, interview, and facility policy review, the facility failed to identify, assess, and coordinate behavioral health services for three (3) of three (3) sampled residents receiving individual psychosocial therapy, Residents #4, #5, and #6, with the potential to affect all 21 residents receiving these services. Specifically, the facility allowed a Licensed Certified Social Worker (LCSW) to provide ongoing cognitive behavioral therapy within the facility without physician oversight, formal referral, or interdisciplinary coordination in which she accepted self-referred residents, regardless of whether clinical need had been identified. Findings Included: A review of the facility's policy, Dementia and Behavioral Health Services, reviewed 02/28/2024, revealed, .It is the policy of this facility that all residents receive the appropriate treatment and services for .necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning .Discussion .6. Specialized services and supports will vary based on the individual's abilities and challenges related to their condition . On 6/11/2025 at 11:00 AM, during a phone interview, the complainant stated that a Licensed Clinical Social Worker (LCSW), employed by the local hospital's behavioral health program, came to the facility weekly and provided therapy sessions to several residents. The complainant explained that the LCSW refused to disclose the names of the residents she was seeing, which prevented the facility from coordinating care, obtaining physician oversight, or monitoring for changes in residents' psychosocial or behavioral health status. She expressed concern that residents may have been receiving therapy without proper clinical justification or oversight, and that the lack of transparency and interdisciplinary involvement could result in unmet needs, fragmented care, or inappropriate continuation of services for vulnerable residents. On 6/12/2025 at 10:00 AM, during an interview with the Social Services Director, she confirmed that the Licensed Clinical Social Worker (LCSW) enters the facility every Thursday to provide therapy services. However, she stated the LCSW does not communicate with facility staff, the Nurse Practitioner (NP), or the physician regarding which residents are receiving services. As a result, the facility is unable to conduct appropriate psychosocial assessments or implement monitoring interventions to evaluate the effectiveness or necessity of the therapy. On 6/12/2025 at 10:30 AM, during an interview with the LCSW, she stated that she had provided therapy services to approximately 21 residents. She explained that all referrals were self-referral by residents who were cognitively intact, with Brief Interview for Mental Status (BIMS) scores of 13 or higher. The LCSW stated that, due to confidentiality, she does not inform facility staff or medical personnel of the residents receiving therapy. She confirmed that the residents independently request services and that she has a pamphlet in the facility's front lobby containing information about her services and contact details. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/2025 at 10:45 AM, during an interview with Registered Nurse (RN) #1, she confirmed that the LCSW did not communicate with nursing staff regarding which residents were receiving therapy. Therefore, there was no coordination of care since there were no physician orders, no behavioral health monitoring or follow-up, as the staff was unaware that therapy services were being provided. On 6/12/2025 at 11:15 AM, during an interview with the Assistant Director of Nursing (ADON), she confirmed that the facility does not receive any information regarding the residents receiving therapy from the LCSW and therefore the facility was unable to initiate monitoring or coordinate care for those residents. On 6/12/25 at 11:30 AM, during an interview, the Administrator confirmed the facility did not coordinate care or provide oversight of the behavioral health services provided by the LCSW which could result in care that conflicts with residents' overall treatment goals. On 6/12/2025 at 1:27 PM, during an interview with the Nurse Practitioner (NP)/Psychiatric Provider, she confirmed that she was not aware the Licensed Clinical Social Worker (LCSW) was providing therapy services to Residents #4, #5, or #6. She stated that she had not issued any referrals for therapy and had not conducted any follow-up monitoring for those residents. On 6/12/2025 at 1:45 PM, during an interview with the Physician, he confirmed that he had not ordered behavioral health therapy for Residents #4, #5, or #6 and was unaware they were receiving such services. He stated that without this information, he was unable to assess their psychosocial status or provide appropriate medical oversight. A record review of a pamphlet displayed in the facility's front lobby titled NOW OFFERING Psychotherapy Services revealed a brochure containing provider details and contact information for the Licensed Clinical Social Worker (LCSW) offering behavioral health services. A record review of the facility's statement, dated 6/12/25, and signed by the Administrator revealed, The facility did not have a referral for (Proper Name of LCSW), no care plan, and no notification of resident representative . regarding Resident #4, Resident #5, and Resident #6. A record review of the LCSW resident service list revealed that she had provided psychosocial services to 21 residents, including Resident #4, Resident #5, and Resident #6. Resident #4 A record review of the admission Record revealed the facility admitted Resident #4 on 4/18/24 with current diagnoses including Fibromyalgia. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review of Section D and Section E indicated there were no behaviors exhibited by the resident and there were no mood symptoms present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255352	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comfort Care Nursing Center	1100 West Drive Laurel, MS 39440

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Resident #4 received Cognitive Behavioral Therapy weekly and bi-weekly as needed on the following dates: December 5, 2024, December 12, 2024, December 19, 2024, January 9, 2025, January 16, 2025, January 22, 2025, January 30, 2025, February 20, 2025, February 27, 2025, March 6, 2025, and March 19, 2025 for Major Depressive Disorder. Patient declined visits on February 6, 2025 and February 13, 2025. Resident #5 A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Sacral Spina Bifida without Hydrocephalus. A record review of Optional MDS with an ARD of 5/13/25, revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Further review of Section D and Section E revealed there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided once a month to Resident #5 on December 19, 2024, January 9, 2025, February 6, 2025, March 6, 2025 and May 29, 2025 for Depression. Patient declined April 2025 visit. Patient discharged from services on May 29, 2025, due to completion of treatment plan. Resident #6 A record review of the admission Record revealed the facility admitted Resident #6 on 12/15/23 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Optional MDS with an ARD of 4/15/25 revealed Resident #6 had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of Section D and Section E revealed the resident did not exhibit any behaviors or there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided bi-weekly to Resident #6 on January 16, 2025, January 22, 2025, February 6, 2025, February 20, 2025, March 6, 2025, and March 20, 2025 and May 29, 2025 for Depression. Patient declined visits from April 3, 2025-May 29, 2025. Patient continues to be seen bi-weekly in accordance with treatment plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255352	A. Building B. Wing	06/12/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure complete and readily accessible medical records were maintained for (3) of (3) sampled residents receiving individual psychosocial therapy, Residents #4, #5, #6, with the potential to affect all 21 residents receiving psychosocial therapy. Specifically, the therapist maintained resident therapy documentation separately from the facility's medical record and did not share or integrate the documentation into the residents' facility medical records. Findings included: A review of the facility's policy titled, Medical And Personal Resident Records, reviewed 01/24/2024, revealed, .It is the policy .that the resident's personal and medical records shall be maintained in accordance with professional standards and practice Discussion: 1. The medical record shall be completely and accurately documented, readily accessible .to facilitate retrieval and compiling of information . On 6/11/2025 at 11:00 AM, during a phone interview with the complainant, she stated that a Licensed Clinical Social Worker (LCSW), employed by the local hospital's behavioral health department, provided therapy to several residents and stored all related documentation in a locked cabinet to which only the LCSW had access. The complainant reported that the LCSW refused to allow the Interdisciplinary Team (IDT) to review these records. As a result, the facility's medical record for each resident receiving these services was incomplete due to lack of access to pertinent clinical information. On 6/12/2025 at 10:00 AM, during an interview with the facility Social Services Director, she confirmed that the Licensed Clinical Social Worker (LCSW) visits the facility on Thursdays and independently provides therapy to residents. She stated that the LCSW does not share progress notes or any other documentation related to the services being provided. On 6/12/2025 at 10:30 AM, during an interview with the Licensed Clinical Social Worker (LCSW), she stated that she had provided therapy services to approximately 21 residents in the facility. The LCSW confirmed that she does not provide the facility with any documentation related to the services rendered, citing confidentiality. On 6/12/2025 at 10:45 AM, during an interview with Registered Nurse (RN) #1, she stated that she was not aware of which residents LCSW was treating, and there was no documentation available within the facility ' s medical record system regarding the therapy services rendered by the LCSW. On 6/12/2025 at 11:30 AM, during an interview with the Assistant Director of Nursing (A-DON), she confirmed that all services provided to residents, including psychosocial therapy, should be incorporated into the resident ' s computerized charting system at the facility. The absence of documentation in the facility ' s record system prevented staff, physicians, and interdisciplinary team members from being aware of ongoing therapy services. Resident #4 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the admission Record revealed the facility admitted Resident #4 on 4/18/24 with current diagnoses including Fibromyalgia. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review of Section D and Section E indicated there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Resident #4 received Cognitive Behavioral Therapy weekly and bi-weekly as needed on the following dates: December 5, 2024, December 12, 2024, December 19, 2024, January 9, 2025, January 16, 2025, January 22, 2025, January 30, 2025, February 20, 2025, February 27, 2025, March 6, 2025, and March 19, 2025 for Major Depressive Disorder. Patient declined visits on February 6, 2025 and February 13, 2025. Resident #5 A record review of the admission Record revealed the facility admitted Resident #5 on 5/30/23 with current diagnoses including Sacral Spina Bifida without Hydrocephalus. A record review of Optional MDS with an ARD of 5/13/25, revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Further review of Section D and Section E revealed there were no behaviors exhibited by the resident and there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided once a month to Resident #5 on December 19, 2024, January 9, 2025, February 6, 2025, March 6, 2025 and May 29, 2025 for Depression. Patient declined April 2025 visit. Patient discharged from services on May 29, 2025, due to completion of treatment plan. Resident #6 A record review of the admission Record revealed the facility admitted Resident #6 on 12/15/23 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Optional MDS with an ARD of 4/15/25 revealed Resident #6 had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of Section D and Section E revealed the resident did not exhibit any behaviors or there were no mood symptoms present. A record review of a written statement, dated 6/12/25 and signed by the LCSW revealed that Cognitive Behavioral Therapy was provided bi-weekly to Resident #6 on January 16, 2025, January 22, 2025, February 6, 2025, February 20, 2025, March 6, 2025, and March 20, 2025 and May 29, 2025 for Depression. Patient declined visits from April 3, 2025-May 29, 2025. Patient continues to be seen bi-weekly in accordance with treatment plan.