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 _____	07/02/2019

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MCCOMB NURSING AND REHABILITATION CENTER LLC	415 MARION AVE MCCOMB, MS 39648

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F 000	INITIAL COMMENTS **Amended 2567: F558 changed to F810 with additional grammatical amendments.** Based on administrative review the Statement of Deficiency was amended on 8/5/19. The State Survey Agency (SA) conducted an annual recertification survey from 06/30/19 through 07/02/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited the regulatory deficiencies F623, F641, F693, F810, and F812. At the time of the survey, the census was 135 and the facility held a license for 146 beds.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		8/26/19

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

Electronically Signed | 08/07/2019

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 3 Based on staff interview, record review, and facility policy review, the facility failed to notify the Resident Representative in writing of a transfer to an acute care hospital for one (1) of three (3) residents reviewed for hospitalizations, Resident #87. Findings include: A review of the facility's policy titled, "Discharge and Transfer Policies-Involuntary", with a revision date of 01/15, revealed: The facility reserves the right to transfer a resident deemed acutely ill by the physician to a hospital or other facility better equipped to meet the residents' health needs. If transferred to another facility upon order of the physician, a two-copy transfer form is completed. One copy is sent with the resident and the other is filed in the resident's record. The resident may be transferred or discharged only when the Executive Director, in consultation with the resident's designated representative, determines that one or more following criteria are met (which included): b. The Facility may involuntary transfer or discharge the Resident because: (a) the Resident's health has improved and the Resident no longer requires the Facility's services; or (b) because the Resident's health needs can no longer be met in the facility; or the Resident's urgent medical needs require immediate transfer or discharge. Prior to resident being transferred or discharged, the facility must provide a written notice to the resident, and if known, a family member or legal representative of the resident. This must be issued at least 30 days before the resident is transferred or discharged. Record review of the Admission/Discharge Minimum Data Set (MDS) Assessment, with an	F 623	Please consider this plan of correction as McComb Nursing and Rehabilitation Center, LLC, credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State Law The Business Office Manager notified Resident #87's Resident Representative on August 5, 2019 in writing, by certified mail regarding a transfer to an acute care hospital that occurred on May 6, 2019. Residents being transferred to an acute care hospital have the potential to be affected. The Executive Director in-serviced the Business Office Manager and the Assistant Business Office Manager on July 22, 2019 regarding providing written notification to the Resident Representative upon the resident's transfer to an acute care hospital.	

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F 623	Continued From page 4 Assessment Reference Date (ARD) of 05/06/19, revealed the Discharge Return was Anticipated. The MDS indicated the discharge status as an acute hospital. The Departmental Notes, dated 05/06/19 at 7:32 PM, revealed Licensed Practical Nurse (LPN) #1 was called to the resident's room by a staff member, and it was noted the resident's brief with large amount of bright red blood. The nurse indicated care was provided, and the blood was noted to be coming from the rectum and the resident was transferred to the hospital. A review of the hospital Discharge Summary (DC), dated 05/08/19, documented the resident was admitted for Acute Lower Gastrointestinal (GI) Bleed. On 07/01/19 at 10:42 AM, an interview with the Business Office Manager (BOM), revealed she did not send the Resident Representative (RR) a notification of transfer to the hospital because the resident was discharged from the facility. She also stated she does not have a notification for this resident. On 07/01/19 at 11:20 AM, an interview with the BOM revealed, she did not notify the RR in writing of the resident's discharge to the hospital. She also stated, the RR opted not to hold the bed, and therefore the resident was discharged from the facility. On 07/02/19 at 10:28 AM, an interview with LPN #2 revealed, the facility anticipated the resident returning to the facility.	F 623	The Executive Director will perform a weekly audit beginning July 22, 2019 regarding transfers to an acute care hospital for four weeks and then a monthly audit for five transfers to an acute care hospital for two months. Negative findings will be addressed. The Executive Director will submit negative findings for three consecutive months to the Quality Assurance Committee and the Quality Assurance Committee will make recommendations as necessary regarding negative findings.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/26/19

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F 641	Continued From page 5 resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) to include Activities of Daily Living, Pre-admission Screening Assessment Resident Review (PASARR), anticoagulant, and tube feedings for four (4) of 30 MDS assessments reviewed. Resident #84, #87, #96, and #129. Findings include: A review of the facility policy's titled "MDS Assessment", dated 11/17, revealed the team member's signatures will attest to the completion/accuracy of the assessments. A review of the Resident Assessment Instrument (RAI) manual revealed the process has multiple regulatory requirements that require that the assessment accurately reflect the resident's status. Resident #84 Record review revealed Resident #84's Pre-Admission Screening and Resident Review (PASARR), Level II was completed on 05/13/16, with recommendations. Review of the Annual Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 02/02/19, revealed Resident #84 was not coded to have a Serious Mental Illness in section A1500, but had a diagnosis which included Schizophrenia. Interview with Registered Nurse (RN) #1, on	F 641	The Minimum Data Set Coordinator modified Resident #84's Minimum Data Set dated 02/02/19 on July 29, 2019 to include coding of a Serious Mental Illness in section a1500. The Minimum Data Set Coordinator modified Resident #87's Minimum Data Set dated 05/06/19 on July 1, 2019 to include coding of a tube feeding. The Minimum Data Set Coordinator modified Resident #96's Minimum Data Set dated 06/04/19 on August 6, 2019 to include Activities of Daily Living coding of resident as limited assist with Activities of Daily Living. The Minimum Data Set Coordinator modified Resident #129's Minimum Data Set dated 06/17/19 on July 29, 2019 to include deleting the coding of an anticoagulant. Residents that have a Minimum Data Set completed have the potential to be affected. The Executive Director in-serviced the Interdisciplinary Team on 07/22/19 regarding accurate coding of a Minimum Data Set. The Interdisciplinary Team consisted of the Minimum Data Set Coordinator, the Minimum Data Set Registered Nurse, the Minimum Data Set Licensed Practical Nurse, the Activity	

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F 641	Continued From page 6 07/01/19 at 10:13 AM, confirmed the Annual MDS with the ARD of 02/02/19, noted in section A1500, that Resident #84 was not evaluated by PASARR, and section A1510A was left blank for Serious Mental Illness. RN #1 confirmed the resident did have a diagnosis, which included Schizophrenia, and was checked in section 16000. RN #1 confirmed the assessment was not accurate, and that this assessment should have been coded for Serious Mental Illness. Resident #87 A review of the Physician Orders revealed an order, dated of 06/05/19, for Jevity 1.5 by Percutaneous Endoscopic Gastrostomy (PEG) tube at 45 milliliter/hour (ML/HR) continuous with 20 ML of free water flush every hour for 24 hours and total 24 hour tube intake. The physician orders also indicated nothing by mouth (NPO) and flush PEG tube with 180 cubic centimeters (CCs) of water every six (6) hours. Check residual every six (6) hours, hold if greater than 60 CCs and notify the physician. Check placement of PEG prior to medication, feedings, and flushes. Flush with 15 CCs of water prior to medications, mix each medication with five (5) CCs of water, administer one at a time flushing with 15 CCs of water between each medication. Flush with 15 CCs of water after last medication. Clean site with normal saline (NS) and cover with sponge daily. Review of the comprehensive Admission/Discharge MDS assessment, with an Assessment Reference Date (ARD) of 05/06/19, revealed the MDS was not coded to include tube feeding. The Comprehensive Care Plan, with and onset	F 641	Director, the Social Service Director, the Social Service Assistant, the Dietary Manager. The Minimum Data Set Coordinator will audit ten Minimum Data Set assessments a week beginning August 5, 2019 for four weeks and then ten Minimum Data Sets assessments a month for two months to ensure accurate coding. Any negative findings will be corrected. The Minimum Data Set Coordinator will submit audit findings for three consecutive months to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary regarding negative findings.	

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F 641	Continued From page 7 date of 05/16/19, included interventions for tube feedings. Review of the resident's Diagnosis and Allergy List indicated the resident had a diagnosis of Dysphagia following Cerebral Infarction and Encounter for Attention to Gastrostomy. On 06/30/19 at 11:00 AM, an observation revealed Resident #87 was lying in bed, awake, with the head of bed (HOB) up at least 45 degrees. He had a tube feeding of Jevity 1.5 at 45 cubic centimeter/hour (CC/HR) by a feeding pump. On 07/01/19 at 4:39 PM, an interview with Registered Nurse (RN) #4, revealed the Admission/Discharge MDS assessment, with an ARD of 05/06/19, was not coded correctly to include tube feeding, and that was an inaccurate MDS assessment. Resident #96 Record review of the MDS, with an ARD of 03/17/2019, revealed Resident #96 was limited assist with Activities of Daily Living (ADLs) with set up help only. Record review of the MDS, with an ARD of 06/4/2019, revealed Resident #96 required extensive assist with ADLs, with staff providing weight bearing assist. This assessment revealed Resident #96 had a decline in the ADLs. Record review of the Restorative Notes revealed the resident had been receiving Restorative care starting, on 02/11/2019 until present. Restorative Notes, dated 06/17/2019, revealed Resident #96 was tolerating the restorative program well	F 641		

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F 641	Continued From page 8	F 641		

without difficulty. Resident #96 was still participating in therapeutic exercises, and showing fair progress, but refused restorative care some days. Resident #96's excuse for refusing the restorative care was pain to the left leg. Pain was reported to the floor nurse each time the resident refused. Resident #96 was able to perform three (3) sets/three (3) reps of Active Range of Motion (AROM) to bilateral lower extremities with one (1) rest period after each set. Resident #96 was able to ambulate 50 feet with two (2) rest periods. Resident #96 ambulated with one (1) person assist with a rolling walker and gait belt for safety. Unsteady gait was noted. Restorative Certified Nursing Assistant (RCNA) will continue to encourage resident and focus on building stamina slowly and safely. Restorative will continue therapeutic regimen to help prevent functional decline and foster independence in self-care skills.

An observation, on 07/01/19 at 9:57 AM, revealed Resident #96 was sitting in a wheelchair watching television, speech was slurred, but was able to make simple needs known. Certified Nursing Assistant (CNA) assisted Resident #96 up out of the wheelchair. The CNA assisted Resident #96 to the bathroom. Resident #96 was able to transfer to the toilet without assistance.

During an interview, on 07/01/19 at 10:06 AM, the Speech Therapy (ST) Manager revealed Resident #96 was discharged from Occupational Therapy, on 05/01/2019, due to no longer requiring the skills for occupational therapy, however Resident #96 required restorative therapy. The ST Manager stated the CNAs and Resident #96 was trained on proper use of wheel chair brakes and grab bars for toilet transfers with

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F 641	Continued From page 9 return demonstration performed and observed by the therapist. The ST Manager also said Resident #96 was stand by assist at the time of discharge. The ST Manager said she has not seen a decline in Resident #96's status. Record review of the Care Plan revealed Resident #96 had a self-care deficit, and the potential for falls and skin breakdown related to (r/t) impaired mobility with right sided hemiplegia/ Cardiovascular Accident (CVA), Anemia, Bowel and Bladder Incontinency. Interventions included: One (1) person assist for transferring, bathing, dressing and toileting. However according to the MDS, dated 10/10/2018, upon admission, revealed the resident was independent for transfers and required only staff supervision or touching for assistance for toileting, and the resident needed some help with dressing. During an interview, on 07/02/19 at 11:04 AM, revealed the Director of Nursing (DON) said she was not aware of this resident having a decline in the ADLs. The DON said she thought it was because the resident had a Urinary Tract Infection (UTI). The DON also said she thought the resident was getting Restorative care. The DON said the MDS was not correct. The resident is still stand by assist with ADLs. During an interview, on 07/02/19 at 12:38 PM, Registered Nurse (RN) #4/Care Plan Nurse confirmed she made a mistake on the June MDS. RN #4 said she coded the MDS according to the nurse's notes on her look back period. RN #4 said the resident is limited assist with ADLs. A review of the facility's Face Sheet revealed the facility admitted Resident #96, on 10/03/2018,	F 641		

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F 641	Continued From page 10 with diagnoses, which included Vascular Dementia , Hemiplegia and Overactive Bladder . A review of Resident #96 Quarterly MDS, with an ARD of 6/04/2019, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact. Resident #129 A review of Resident #129's MDS, with an ARD of 06/17/19, revealed documentation for an anticoagulant medication for seven (7) days under section N0410E. A review of Resident #129's Physician's Orders revealed the resident was currently on Plavix (a medication to prevent the blood platelets from sticking together and/or form a blood clot), with a start date of 01/12/18. A review of Resident #129's Medication Administration Record (MAR) revealed the resident was administered Plavix for the month of June 2019. An interview, on 07/02/19 at 9:36 AM, with Licensed Practical Nurse (LPN) #2/MDS Nurse, revealed Resident #129's MDS, with an ARD date of 06/17/19, was inaccurately coded for an anticoagulant. LPN #2 stated Resident #129 was only on Plavix, and that was an antiplatelet. LPN #2 also said the MDS was completed by a nurse that was not currently working at the facility. LPN #2 stated the policy they use was the RAI manual to guide the staff to document on the MDS.	F 641		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		8/26/19

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F 693	Continued From page 11 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide Resident #87's tube feeding site care in a manner to prevent the possibility of cross contamination/spread of infection. Licensed Practical Nurse (LPN) #1 failed to wipe and/or clean the feeding tube site in the appropriate direction and rotate the Normal Saline soaked gauze with each wipe, or change to a new gauze. This concern was identified for one (1) of four (4) tube feeding site care observations. Findings include:	F 693	Licensed Practical Nurse #1 was in-serviced by the Licensed Practical Nurse, Staff Development Coordinator, on July 10, 2019 with return demonstration regarding wiping and/or cleaning Resident #87's feeding tube site in the appropriate direction and rotating the Normal Saline soaked gauze with each wipe. Sixteen Residents with a feeding tube have the potential to be affected. No other residents were affected. The Staff Development Coordinator,	

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	255101	A. BUILDING _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCOMB NURSING AND REHABILITATION CENTER LLC	415 MARION AVE MCCOMB, MS 39648

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F 693	Continued From page 12 Review of the facility's policy titled, "Daily Cleaning of G/J (Gastrostomy/Jejunostomy) Tube Site", dated 08/11, revealed a resident with a Gastrostomy or Jejunostomy tube will have the tube site cleaned daily. Further review of the policy revealed the Procedures did not include steps for the actual cleaning procedure related to direction of wipes and rotation of gauze to prevent contamination of the cleaned areas. Step 3. Cleanse with soap and water and dry during routine morning care or at other designated time. Step 4. If site appears red, inflamed, has drainage or the resident complains of pain at site, notify the nurse. Step 5. The nurse will notify the physician if indicated for further orders. A review of the Physician Orders revealed an order, dated 06/05/19, for Jevity 1.5 per Percutaneous Endoscopic Gastrostomy (PEG) tube at 45 milliliter (ML)/HR continuous with 20 ML of free water flush every hour for 24 hours and total 24 hour tube intake. The physician orders also indicated, nothing by mouth (NPO), and flush PEG tube with 180 cubic centimeters (CCs) of water every six hours. Check residual every six hours, hold if greater than 60 cc and notify the physician. Check placement of PEG prior to medications, feedings, and flushes. Flush with 15 CCs of water prior to medications, mix each medication with 5 CC of water, and administer one at a time flushing with 15 CCs of water between each medication. Flush with 15 CCs of water after last medication. Clean site with normal saline (NS), and cover with sponge daily. Review of the Comprehensive Care Plan, with an onset date of 05/16/19, revealed the Approaches included enteral feedings as	F 693	Licensed Practical Nurse in-serviced Licensed Practical Nurses and Registered Nurses on July 1, 2019 thru August 5, 2019 and provided return demonstration regarding cleaning the tube feeding site. The Director of Nursing will monitor the cleaning of three tube feeding sites two times a week for four weeks and one time a week for one month. The Director of Nursing will submit negative findings to the Quality Assurance Committee for two consecutive months. The Quality Assurance Committee will make recommendations when necessary regarding negative findings.	

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F 693	Continued From page 13 ordered/recommended, weights per facility policy, Registered Dietician (RD) as needed, and flushes as ordered/recommended. On 6/30/19 at 11:00 AM, an observation revealed Resident #87 lying in bed awake. On 7/01/19 at 3:19 PM, an observation of Licensed Practical Nurse (LPN) #4 revealed she performed gastric tube site care. LPN #4 explained she had washed her hands and set up her supplies and barrier prior to the observation of care. Using clean gloved hands, LPN #4 removed the resident's soiled 4x4 gauze dressing, removed her soiled gloves, and applied clean gloves without washing her hands or using Alcohol Based Hand Gel (ABHG). She poured normal saline (NS) into a plastic cup that had 4x4 gauzes in it. LPN #4 took one (1) of the NS moistened 4x4 gauzes and wiped half way around the resident's gastric tube site on the left side of the tubing in a downward motion once, LPN #4 rotated the gauze, and wiped three (3) more times, without rotating the gauze, and then discarded the gauze dressing. She then retrieved another NS moistened gauze from the plastic cup and wiped the resident's gastric tube site in an upward motion on the right side of the tubing once, rotated the gauze dressing, wiped completely around the tubing, then in a back forth motion twice on the right side of the tubing. LPN #4 placed a clean dry dressing to the resident's gastric tube site, taped it in place, disposed of the soiled items, and washed her hands. On 7/01/19 at 4:23 PM, an interview with the Director of Nursing (DON) revealed the nurse should not have wiped in a back and forth motion to prevent the spread of infection.	F 693		

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F 810	Continued From page 14	F 810		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to assess and evaluate Resident #61's need for assistive devices to assist with eating. This concern was identified for one (1) of eleven (11) residents assessed for nutrition. Findings include: Review of a untitled document written on the facility's letterhead, dated July 2, 2019, provided and signed by the Administrator, revealed that in this facility, through nursing observations, residents can be referred to Restorative Nursing and/or Therapy services to accommodate resident's needs. When a policy on the accommodation of needs was requested, the facility provided this document. Review of Resident #61's medical record document titled, "Physician Orders," dated June 2019, revealed that an order for a Regular Puree diet with a divided plate had been in place since 01/14/13. Review of Resident #61's medical record document titled, "Departmental Notes," dated 06/12/19, revealed the Registered Dietitian (RD)	F 810	Resident #61 was screened by Occupation Therapy on July 2, 2019 regarding assistive devices with meals. Resident #61 is currently receiving services from Occupational Therapy for using assistive devices during meals. Residents that require assistance and/or assistive devices with meals have the potential to be affected. The Licensed Practical Nurse, Staff Development Nurse in-serviced nursing staff on July 18, 2019 - July 30, 2019, regarding observing residents during meals for the need of assistance and/or assistive devices with eating and drinking. Residents identified as needing assistive devices will be referred to the therapy department to be screened for therapy services. The assigned Licensed Practical Nurse will observe ten residents during meals, three meals a week, beginning August 8, 2019 for four weeks and monthly for two months to ensure residents are receiving assistive devices as needed. The Director	8/26/19

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F 810	Continued From page 15 entered a note where she documented Resident #61 had a significant weight loss. The note indicated the RD recommended no changes to the Plan of Care (POC) be made at this time. Review of Resident #61's medical record document titled, "Weight Change History," dated 06/10/19, revealed there was a 10 pound (lb.) change in the weights between 05/08/19 and 06/10/19. The document indicated that on 05/08/19, Resident #61's weight was 157 lbs, and on 06/10/19 Resident #61's weight was 148 lbs. During a dining observation of the lunch meal, on 06/30/19 at 11:45 AM, Resident #61 was spilling her food on her clothes and the table where she was seated. Resident #61 had difficulty guiding the standard sized spoon from her plate to her mouth successfully. Resident #61 was drinking from a regular glass of tea, and spilled her tea on herself. Staff members from the Dietary Department were present in the dining room, but Resident #61 did not receive any assistance from anyone with her meal. Resident#61 had four separate episodes of harsh coughing during the meal observation. During a lunch meal dining observation, on 07/01/19 at 11:23 AM, Resident #61 was present in the main dining room. A staff member from the Dietary Department, applied a protective garment around Resident #61's neck, also set up Resident #61's dining tray, opened her milk, and served her the lunch meal. Resident #61 was now using a larger sized spoon utensil to eat her meal. Resident #61 consumed about 90 percent (%) of the food on her plate, and the remaining 10% of the food on Resident #61's plate was now on the table and on her clothes. Resident #61 continued	F 810	of Nursing will submit findings to the Quality Assurance Committee for three consecutive months. The Quality Assurance Committee will make recommendations as necessary.	

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F 810	Continued From page 16 to have difficulty guiding the larger spoon utensil into her mouth, causing the food to spill. It was observed that the food spilled, because Resident #61 was attempting to scoop the food on her spoon from the side of her plate. During an interview, on 07/02/19 at 9:00 AM, the Speech Therapist (ST)/Therapy Team Leader revealed that according to Resident #61's medical records, there was no documentation the resident was spilling her food while eating. The ST stated she was unaware of Resident #61's recent weight loss. The ST stated she would see to it that Resident #61 was observed at meal times and see if there is a need for adaptive utensils to aid the resident while eating. An observation and interview, on 07/02/19 at 11:45 AM, revealed Resident #61's Occupational (OT) and Speech Therapist (ST) were present to assess the resident during the meal. Resident #61 continued to spill her food on herself. The ST and OT stated a recommendation would be made for the use of a larger and thicker divided plate, and a smaller spoon to be used by Resident #61 for better control and success with the resident's meal. During an interview on, 07/02/19 at 11:15 AM, Licensed Practical Nurse (LPN) #3/Restorative Nurse, revealed Resident #61's breakfast and lunch meals are monitored. . LPN #3 stated Resident #61 had been gradually spilling more of her food for a while now. LPN #3 stated she had not reported or documented Residents #61 has had a decline in being able to coordinate her utensils and her food. LPN# 3 also stated she had not been at work for the last two (2) days.	F 810		

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F 810	Continued From page 17 During an interview, on 07/02/19 at 11:20 AM, Registered Nurse (RN) #2 revealed she had been in the dining room for the past two (2) days to supervise and watch the residents while eating. RN #2 stated she was familiar with Resident #61, and was aware the resident often spilled her food. RN #2 stated Resident #61 had good days and bad days. RN #2 also stated someone from the Therapy Department had taken Resident #61 to the therapy gym and observed her during the lunch meal. Review of the Face Sheet revealed Resident #61 was admitted by the facility on 05/26/06, with diagnoses to include Unspecified Intellectual Disabilities and Aphasia.	F 810		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		8/26/19

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F 812	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to store, prepare and serve food under a safe and sanitary manner; as evidenced by failure to document freezer and refrigerator temperature checks for two (2) of three (3) days of the survey, pork chops cooked and served to the residents after being thawed in the sink without room temperature running water, and failure to maintain a 200 parts per million (ppm) sanitizer level for the 3-compartment sink for two (2) of three (3) staff observed to check the sanitizer lever. These identified concerns placed all residents who received food/nourishment from the kitchen at risk for food borne illnesses. Findings include: Review of the facility's policy titled, "Guidelines for Staff Preparing Food Fundamentals to Prevent Food Borne Illness", dated 2011, noted foods should never be thawed on a counter or at room temperature. This policy noted foods are thawed in the refrigerator, under freely flowing, room temperature water or in the microwave and immediately cooked and served. Review of the facility's policy titled, "EPA (Environmental Protection Agency) registered no rinse Quat sanitizer" manufacturer's instructions noted the acceptable range for testing should be 150, 200, or 400 parts per million (ppm). Observations and interview during the initial tour of the kitchen, with Dietary Department Cook #1, on 06/30/19 at 9:10 AM, revealed pork chops thawing in the sink with no running water. The	F 812	Cook #1 was in-serviced on June 30, 2019 by the Registered Dietician regarding the procedure for thawing meats in the sink, and maintaining a 200 parts per million (ppm) sanitizer level for the three compartment sink. The Executive Director suspended Cook #1 on June 30, 2019 immediately upon gaining knowledge of the thawing of the pork chops and the sanitizer level of the three compartment sink. Cook #1 was terminated by the Executive Director on July 9, 2019. There were no residents identified with a food illness related to the thawing of the pork chops or regarding the failure to maintain a 200 parts per million sanitizer level for the three compartment sink. Residents receiving meals from the dietary department have the potential to be affected. Dietary staff were in-serviced by the Registered Dietician on July 30, 2019 regarding the procedure for thawing meats in the sink and maintaining a 200 parts per million(ppm)sanitizer level for the three compartment sink. The Dietary Manager in-serviced dietary staff on July 18, 2019 and July 19, 2019 regarding storing, preparing, and serving food under a safe and sanitary manner. The in-service content included documenting freezer and refrigerator temperature checks in a timely manner, procedure for thawing meats in the sink, and	

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F 812	Continued From page 19 pork chops were not in any type of container, just lying in the sink. The 3-compartment sink sanitizer sink, tested zero (0) ppm on the test strip after submersion for 10 seconds. There was no documentation for the 3-compartment sink sanitizer level since the 06/28/29, morning check on the check sheet. The main freezer had no thermometer inside the freezer, only on the outside. The "Equipment Temperature Log" was last documented, on 06/28/19, for the morning and noon checks for the Cooler and Freezer temperatures. The Milk Coolers had no documentation for temperatures on the "June 2019 Temperature Log" for 06/29/19, and the AM shift for 06/30/19. Dietary Department Cook #1 was observed filling the 3-compartment sink with plain water, and pushing the button on the sanitizer a couple of times. Again the 3-compartment sink sanitizer tested zero (0) ppm when the strip was held for ten (10) seconds in the water solution. An interview during this time with Cook #1 revealed she stated when you are unable to sanitize dishes in the 3-compartment sink it could cause germs, infections and food disease for the residents. Cook #1 confirmed there was not any running water through the sanitizer for the 3-compartment sink, and did she did not know to do that. She stated she had been working at this facility in the kitchen for 13 years and did not know to do that until today. On 06/30/19 at 2:40 PM, an observation revealed Cook #1 retested the 3-compartment sink's sanitizer compartment and obtained a reading of 200 ppm. Cook #1 was asked about the pork chops thawing in the sink earlier in the day, and she confirmed they were in the sink and thawing. She confirmed they were baked and barbequed, and later served to the residents. Cook #1 stated	F 812	maintaining a 200 parts per million (ppm) sanitizer level for the three compartment sink. The Dietary Manager will perform a daily audit five days a week for four weeks beginning July 22, 2019 and then weekly for two months regarding documentation of the freezer and refrigerator temperatures, procedure for thawing meats in the sink, and maintaining a 200 parts per million (ppm) sanitizer level for the three compartment sink. The Dietary Manager will submit negative findings to the Quality Assurance Committee for three consecutive months. The Quality Assurance Committee will make recommendations as necessary regarding negative findings.	

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F 812	Continued From page 20 the pork chops should have been in a strainer with water running over them, and not directly in the sink. Cook #1 stated she did clean the sink prior to placing the pork chops directly in the sink.	F 812		

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	255101	A. BUILDING **01 - MAIN WING 01** B. WING _____	**07/01/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		8/26/19

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

Electronically Signed | 08/07/2019

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.

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K 363	Continued From page 1 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 section 19 3.6.3.5. This deficiency affected one (1) of the seven (7) smoke compartments and 11 of the 133 residents in the facility during the survey. Findings include: On 7/1/19 at 10:35 AM, observation revealed no positive latching device on the corridor door of the Wing 2 Day Room of the facility. The Wing 2 Day Room was incapable of resisting the passage of smoke throughout the facility.	K 363	Please consider this plan of correction as McComb Nursing and Rehabilitation Center, LLC, credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State Law Maintenance personnel installed a positive latching device on the corridor door of the Wing 2 Day Room on July 3, 2019 Residents residing on the hall the Wing 2 Day Room is located had the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255101	A. BUILDING **01 - MAIN WING 01** B. WING _____	**07/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCOMB NURSING AND REHABILITATION CENTER LLC	**415 MARION AVE** **MCCOMB, MS 39648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 2	K 363	Maintenance personnel were in-serviced by the Executive Director on July 15, 2019 regarding ensuring corridor openings are properly protected. Maintenance personnel performed an audit of all corridor openings to ensure the corridor openings are properly protected and will perform audits on 5 doors weekly for four weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255101	A. BUILDING **02 - 1985 WING** B. WING _____	**07/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCOMB NURSING AND REHABILITATION CENTER LLC	**415 MARION AVE** **MCCOMB, MS 39648**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/07/2019

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.

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 _____	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCOMB NURSING AND REHABILITATION CENTER LLC	415 MARION AVE MCCOMB, MS 39648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Survey conducted on 07/01/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 08/07/2019

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.