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 _____	05/10/2018

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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 05/3/18 through 05/10/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F641, F656, and F690. The facility was licensed for 140 beds, and had a census of 125 at the time of survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for two (2) of 25 MDS assessments reviewed, Residents #328 and Resident #329. Findings include: Review of the facility's policy titled, "MDS Assessment", dated 11/17, revealed the facility shall conduct interdisciplinary assessments using the MDS item sets as defined by the federal regulations. The interdisciplinary team will complete specified portions of the MDS, and the Registered Nurse (RN) designated by the facility will assure that all disciplines have completed their portion of the MDS. Review of documentation on facility letterhead, signed by the Director of Nursing (DON), dated	F 641	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. 641 The MDS Coordinator modified the MDS for resident #328 on 05/18/2018 to include	6/23/18

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

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F 641	Continued From page 1 5/10/18, revealed the MDS is completed per the guidelines in the RAI (Resident Assessment Instrument) manual. Resident #328 Observation, on 05/08/18 at 9:35 AM, revealed Resident #328 with an indwelling urinary catheter. Review of Resident #328's MDS, with an Assessment Reference Date (ARD) of 4/19/18, revealed the section for Bladder and Bowel Continence indicated the indwelling catheter was not checked. Record review revealed Resident #328 had a physician's order, dated 4/16/18, for a 18 French (FR) Foley catheter with a 10 cubic centimeter (cc) balloon. Review of the Face Sheet revealed Resident #328 was admitted by the facility on 4/13/18, with the included diagnoses Chronic Kidney Disease, Essential Hypertension, and Diabetes Type II. Review of Resident #328's Admission MDS, with an ARD of 4/19/18, revealed the resident's Cognitive Skills for Decision Making was coded a zero (0), which indicated no cognitive impairment. Resident # 329 On 05/07/18 at 2:45 PM, an observation revealed Resident #329 had an indwelling urinary catheter to gravity flow at the bedside. Review of the Annual MDS, with an ARD of 3/20/18, revealed the section for Bowel and Bladder Continence was not checked for an	F 641	indwelling catheter. The MDS Coordinator modified the MDS for resident #329 05/18/2018 to include indwelling catheter. Residents that have an MDS completed have the potential to be affected. The MDS nursing staff were in-serviced regarding accurate coding of an MDS on 05/21/2018 and 05/29/2018 by the Executive Director. The MDS Coordinator will audit 10 MDS weekly for four weeks and then 10 MDS monthly for two months for accurate coding of the MDS. Any negative findings will be corrected and addressed during QA meeting. The QA committee will make recommendations as necessary regarding negative findings.	

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F 641	Continued From page 2 indwelling catheter, but was checked for an external urinary catheter. Record review revealed a physician's order, dated 1/4/18, for a 16 French Foley indwelling catheter, with a 10 cc balloon for wound healing. During an interview, on 05/09/18 at 11:25 AM, Registered Nurse (RN) #1 stated, "I accidentally marked the wrong thing on the MDS." RN #1 stated she uses the RAI Manual for her guideline in coding of the MDS. During an interview, on 05/09/18 at 11:45 AM, the DON stated the MDS Nurse should document what she assesses.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		6/23/18

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F 656	Continued From page 3 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to follow the Comprehensive Care Plan to ensure appropriate catheter care for one (1) of 25 care plans reviewed, Resident #329. Findings include: Review of the facility's policy titled, "Comprehensive Person Centered Care Plans", dated 03/18, 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. Assigned disciplines will be identified to carry out the interventions.	F 656	656 The LPN repositioned resident #329's catheter drainage bag to the right side of the bed on 5/7/2018. The CNA repositioned resident #329's catheter drainage bag to the right side of the bed on 5/8/2018. LPN observation of the resident and interview with the resident revealed no trauma or pain. The CNA was verbally reminded by the resident's assigned LPN on 5/8/18 regarding the protocol for incontinent catheter care. The licensed and certified nursing staff were in-serviced by the Staff Development Nurse,the Nurse Supervisor, and the Assistant Director of Nursing, regarding	

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F 656	Continued From page 4 Review of Resident #329's Care Plan, dated 04/03/18, revealed, the resident has a foley catheter related to a Stage 4 wound to the buttocks to prevent infection and promote healing. The approaches included to clean around the catheter insertion site daily with soap and water, and avoid pulling on the catheter during cleaning or repositioning. On 05/07/18 at 2:45 PM, an observation revealed Licensed Practical Nurse (LPN) #3 and LPN #5 turned the resident onto his right side, and left the catheter drainage bag hanging on the opposite side of the bed. On 05/07/18 at 3:00 PM, during an interview with LPN #3, revealed she stated the importance of placing the urinary catheter drainage bag on the side of the bed the resident is turned to is, "to keep the catheter tubing from pulling." On 05/08/18 at 8:50 AM, an observation of catheter care performed by Certified Nursing Assistant (CNA) #1 and CNA #2, revealed CNA #2 wiped the resident's penis from the base towards the meatus. She also wiped the catheter tubing near the insertion site without anchoring the catheter to prevent pulling. CNA #1 and CNA #2 pulled Resident #329 up in the bed, and positioned him onto his right side, while the catheter drainage bag remained on the opposite side of the bed. On 05/08/18 at 10:30 AM, during an interview with CNA #2, she stated, "I should have moved the bag to the side he is turned, so it will not pull."	F 656	following the catheter care plan for resident #329 on 06/20/2018-6/22/2018. Residents with care plans for incontinent care, especially residents requiring catheter care have the potential to be affected. Licensed and certified nursing staff were in-serviced by the Staff Development Nurse, the Nurse Supervisor, and the Assistant Director of Nursing, on 06/20/2018 thru 06/22/2018 regarding following the catheter care plan, and the importance of placing the urinary catheter drainage bag on the side of the bed the resident is turned to in order to prevent the catheter tubing from pulling. Licensed and certified nursing staff were in-serviced by the Staff Development Nurse, the Nurse Supervisor, and the Assistant Director of Nursing, on 05/18/2018 thru 06/22/2018 regarding the appropriate direction to wipe the penis and anchoring the catheter when wiping the catheter tubing near the insertion site. Licensed and certified nursing staff were checked off with return demonstration by the Staff Development Nurse and the Nurse Supervisor on 05/18/2018 thru 06/22/2018 regarding providing catheter care. The Director of Nursing will perform 3 catheter care observations weekly for 4 weeks and then monthly for 2 months. Negative findings will be addressed immediately and results will be reviewed during the QA meeting. The QA committee will make recommendations as	

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F 656	Continued From page 5 On 5/08/18 at 4:00 PM, during an interview with CNA #1, she questioned the surveyor, "Are we supposed to wipe from top to bottom?" LPN #2 was present at this time and stated, wiping away from the meatus will prevent infection and bacteria from entering the meatus. On 05/08/18 at 4:45 PM, during an interview with LPN #1/CNA Instructor, revealed she stated, "You're not supposed to go from that way (referring to wiping penis from base to top), so you will not carry infection, germs, or bacteria to the urethra." Review of the facility's Face Sheet revealed, Resident #329 was admitted by the facility on 05/01/17 with diagnoses that included Nontraumatic Intracerebral Hemorrhage Unspecified and Encephalopathy. Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/20/18, revealed the cognitive skills for daily decision making was coded a 3 which indicated severe cognitive impairment.	F 656	necessary regarding the negative findings.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		6/23/18

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F 690	Continued From page 6 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to perform catheter care in a manner to prevent trauma and to prevent possible infection for one (1) of six (6) catheter care observations, Resident #329. Findings Include: Review of the facility's policy titled "Catheter Care" undated, revealed cleanse around the area where catheter enters the urethral meatus with a	F 690	690 The LPN repositioned resident #329's catheter drainage bag to the right side of the bed on 5/7/2018. The CNA repositioned resident #329's catheter drainage bag to the right side of the bed on 5/8/2018. LPN interview with the resident and observation of the resident revealed no trauma or pain. The CNA was verbally reminded by the resident's assigned LPN on 5/8/18 regarding the protocol for incontinent catheter care. The certified nursing assistants were	

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F 690	Continued From page 7 wipe in a downward motion about four (4) inches. Avoid pulling on the catheter during cleansing. On 05/07/18 at 2:45 PM, an observation revealed Resident #329 had an indwelling urinary catheter with a drainage bag and leg strap securing the tubing to the resident's left thigh area. Licensed Practical Nurse (LPN) #3 and LPN #5 turned Resident #329 at this time onto his right side and left the resident's catheter drainage bag hanging on the opposite side of the bed. On 05/07/18 at 3:00 PM. an interview with LPN #3 revealed, she stated it is important to place the urinary catheter drainage bag on the side of the bed that the resident is turned, "to keep the catheter tubing from pulling." Record review of the May 2018 Physician Orders, revealed an order dated 1/4/18 for a 16 French Catheter with a 10CC balloon foley for wound healing. On 05/08/18 at 8:50 AM, an observation of urinary catheter care performed by Certified Nursing Assistant (CNA) #1 and CNA #2 revealed CNA #2 wiped the resident's penis from the base towards the meatus. She also wiped the catheter tubing near the insertion site without anchoring the catheter to prevent pulling. CNA #1 and CNA #2 pulled him up in the bed, and positioned him onto his right side, while the catheter drainage bag remained on the opposite side of the bed. On 05/08/18 at 10:30 AM, an interview with CNA #2 revealed, she stated, "I should have moved the bag to the side he is turned , so it will not pull."	F 690	in-serviced and checked off with return demonstration by the Staff Development Nurse,the Nurse Supervisor, and the Assistant Director of Nursing, on 05/18/2018 thru 6/22/2018 regarding the direction to wipe the penis and anchoring the catheter when wiping the tubing. Licensed and certified nursing staff were in-serviced by the Staff Development Nurse, the Nurse Supervisor, and Assistant Director of Nursing, on 6/20/2018-6/22/2018 regarding repositioning the catheter bag to the side of the bed the resident is facing. Residents who receive incontinent care, especially residents requiring catheter care have the potential to be affected. Licensed and certified nursing staff were in-serviced by the Staff Development Nurse, the Nurse Supervisor, and the Assistant Director of Nursing, on 6/20/18 thru 6/22/2018 regarding the importance of placing the urinary catheter drainage bag on the side of the bed the resident is turned to in order to prevent the catheter tubing from pulling. Licensed and Certified nursing staff were in-serviced by the Staff Development Nurse, the Nurse Supervisor, and the Assistant Director of Nursing, on 05/18/2018 thru 06/22/2018 regarding the appropriate direction to wipe the penis and anchoring the catheter when wiping the catheter tubing near the insertion site. Licensed and certified nursing staff were checked off with return demonstration by the Staff Development Nurse and the Nurse Supervisor on	

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F 690	Continued From page 8 On 05/08/18 at 4:00 PM, during an interview with CNA #2, she responded, "Are we supposed to wipe from top to bottom?" when the surveyor questioned her about Resident #329's catheter care. LPN #2 was present at this time and, stated wiping away from the meatus will prevent infection and bacteria from entering the meatus. On 05/08/18 at 4:45 PM, an interview with LPN #1/CNA instructor revealed, she stated, "You're not supposed to go from that way (referring to wiping penis from base to top), so you will not carry infection, germs, or bacteria to the urethra." Review of the facility's Face Sheet revealed, Resident #329 was admitted by the facility on 05/01/17 with diagnoses that included Nontraumatic Intracerebral Hemorrhage Unspecified and Encephalopathy. Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/20/18, revealed the cognitive skills for daily decision making was coded a 3 which indicated severe cognitive impairment.	F 690	05/18/2018 thru 06/22/2018 regarding providing catheter care. The Director of Nursing will perform 3 catheter care observations weekly for 4 weeks and then monthly for 2 months. Negative findings will be addressed immediately and results will be reviewed during the QA meeting. The QA committee will make recommendations as necessary regarding the negative findings.	

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	255101	A. BUILDING **01 - MAIN WING 01** B. WING _____	**05/03/2018**

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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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.2.2.6. This deficiency affected one (1) of 14 exits and 13 of 125 residents in the facility on the day of survey. Findings include: On May 3, 2018 at 1:00 PM, observation revealed cracked, unleveled, and obstructed sidewalk egress from the Therapy Area of the facility.	K 211	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 that 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.	6/7/18

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

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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 211	Continued From page 1	K 211	The cracked, unleveled, and obstructed sidewalk was repaired on 6/7/2018. Residents utilizing the sidewalk have the potential to be affected. The maintenance staff were in-serviced by the Executive Director on 05/22/2018 regarding properly maintaining the exit egress. The Maintenance Director will perform observations on all sidewalks weekly to ensure the sidewalks are properly maintained for four weeks and then monthly for 2 months. Negative findings will be corrected and results will be reviewed during the QA meeting.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire extinguishers as per NFPA 10 7.3.1.2.1, NFPA 1 7.3.3.2 and NFPA 10 7.3.1.1.2. This deficiency affected five (5) of the 12 smoke compartments and 42 of 125 residents in the facility on the day of survey. Findings include: Observation on May 3, 2018 12:45 PM revealed	K 355	The fire extinguisher near room 116, 226, 135, the Class Room, and room 233 were inspected on 5/4/2018 and a collar was installed on the fire extinguishers. The fire extinguishers installed in the facility have the potential to be affected.	5/4/18

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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 355	Continued From page 2 no 12 year hydrostatic inspection verification of service collar installed on the fire extinguishers in the following area of the facility: 1) Fire extinguisher near Room 116 2) Fire extinguisher near Room 226 3) Fire extinguisher near Room 135 4) Fire extinguisher near Room the Class Room 5) Fire extinguisher near Room 233 The fire extinguishers did receive a six-year inspection in 2008.	K 355	The maintenance staff were in-serviced by the Executive Director on 05/22/2018 regarding the importance of ensuring the 12 year hydrostatic inspection verification service collar is installed when the 12 year inspection occurs. The Maintenance Director will audit the fire extinguishers monthly for 3 months to ensure the 12 year hydrostatic inspection verification service collar is installed. Negative findings will be corrected and the results will be reviewed during QA meeting.	

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 _____	**05/03/2018**

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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 | 06/21/2018

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 _____	05/03/2018

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E 000	Initial Comments Survey conducted on 5/3/18 reveals the above facility does NOT meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		

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

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