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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 Complaint Investigations (CI), MS #29018, MS #29180, and MS #29254, at the facility from 6/11/25 through 6/12/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. MS #29018 was investigated for quality of care, employee to resident abuse, discharge and falsified medical records and MS #29180 was investigated for employee to resident abuse, seclusion and resident not treated with dignity and there were no deficiencies cited related to those CIs. MS #29254 was investigated for fraud and quality of care and F580, F656, F658, F742, and F842 were cited. The facility held a license for 126 beds, with a census of 111.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		7/24/25

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

Electronically Signed | 07/02/2025

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: 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	F 580	1) On 07/01/25, the facility Coordinator informed the physician of the 1:1 psychosocial therapy services being provided by a 3rd party provider to all residents receiving those services;	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 2 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	F 580	specifically, Resident #5 and Resident #6. Resident #4 has been discharged. On 07/02/25, the Social Services Director informed the resident representative of the 1:1 psychosocial therapy services being provided by a 3rd party provider to all residents receiving those services; specifically, Resident #5 and Resident #6. Resident #4 has been discharged. 2) The facility has determined that all residents have the potential to be affected by failure to notify the physician and the resident representative of the initiation of psychosocial therapy services. A 100% audit of the resident health record was conducted by the facility Coordinator on 7/2/25 to identify and ensure physician and resident representative notification for all residents identified as receiving 1:1 psychosocial therapy services by a 3rd party provider. Facility identified eleven residents currently receiving 1:1 psychosocial therapy services, one resident has deceased, one resident was discharged from the facility, and the remaining eight residents completed therapy services. 3) On 07/01/25, the Quality Assurance Committee met and recommended development of a policy for Mental Health Services Referral. The Mental Health Services Referral Policy was developed and approved by the Quality Assurance Committee at that time. The Quality Assurance Committee also reviewed the Resident Rights Notification of Changes Policy at that time and approved with no revisions. On 06/30/25, an in-service education	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 3 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. 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	F 580	program began by the Minimum Data Set (MDS) Coordinator, Assistant Director of Nursing, and the facility Coordinator with all licensed nursing staff addressing notification of changes and the policy and procedures for mental health services referral. In-servicing will continue until all licensed nursing staff have received the in-service training. A 1:1 in-service will be conducted by the Administrator and Coordinator with the Licensed Certified Social Worker (LCSW) providing psychosocial services in the facility upon her return to the facility on or around 07/10/25 and prior to providing any further 1:1 psychosocial therapy services for the residents. The in-service will include review of the Mental Health Services Referral Policy and procedures, as well as, the requirement to notify the physician and resident representative when 1:1 psychosocial therapy services are initiated, and of any new orders or treatment services. 4) Beginning 07/03/25, for a period of 3 months, the Social Services Director will audit all medical records of residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker weekly using the Mental Health Services Process Audit form to ensure the physician and resident representative has been notified of initiation of 1:1 psychosocial therapy services. Corrective action will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly times three months beginning 07/23/25, and will	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 4 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.	F 580	continue until such time substantial compliance has been achieved as determined by the Quality Assurance Committee. The Quality Assurance Committee will make any recommendations or changes to ensure compliance.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 5	F 580		

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.

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"

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 6	F 580		

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

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 580	Continued From page 7 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.	F 580		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656		7/24/25

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 8 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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	F 656	1) On 07/01/25, the Minimum Data Set (MDS) Coordinator revised the comprehensive care plan to include services provided to address the psychosocial needs of all residents receiving 1:1 psychosocial therapy services, specifically resident #5 and resident #6. Resident #4 has been discharged from the facility. 2) The facility has determined that all residents have the potential to be affected by failure to develop a comprehensive care plan which includes services provided to address psychosocial needs. A 100% audit of the resident health record was conducted by the facility Coordinator on 07/02/25 to identify and ensure the comprehensive care plan for all residents identified as receiving 1:1 psychosocial therapy services by a 3rd party provider	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 9 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	F 656	has been revised to include those services. Facility identified eleven residents currently receiving psychosocial therapy services, one resident has deceased, one resident was discharged from the facility, and the remaining eight completed therapy services. 3) The Comprehensive Person-Centered Care Plan Policy was reviewed by the Quality Assurance Committee on 07/01/25 and approved with no revisions. On 07/01/25, the Quality Assurance Committee met and recommended development of a policy for mental health services referral. The Mental Health Services Referral Policy was developed and approved by the Quality Assurance Committee at that time. On 06/30/25, an in-service education program began by the MDS Coordinator, the Assistant Director of Nursing, and the facility Coordinator with all licensed nursing staff addressing appropriate development and implementation of a person-centered care plan. In-servicing will continue until all licensed nursing staff have received the in-service education. A 1:1 in-service will be conducted by the facility Administrator and Coordinator with the Licensed Certified Social Worker providing psychosocial therapy services in the facility upon her return to the facility on or around 07/10/25 and prior to providing any further 1:1 psychosocial therapy services for the residents. The in-service will include review of the Mental Health Services Referral Policy, as well as, the Comprehensive Person-Centered Care Plan Policy.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 10 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. 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,	F 656	4) Beginning 07/03/25, for a period of three months, the Social Services Director will audit all medical records of residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker weekly using the Mental Health Services Process Audit form to ensure the residents' care plans have been revised to include all services provided to meet the resident's psychosocial needs. Corrective action will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly times three months beginning 07/23/25, and will continue until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Committee. The committee will make any recommendations or changes to ensure compliance.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 11	F 656		

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

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 12	F 656		

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

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 656	Continued From page 13 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.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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,	F 658	1) On 07/01/25, the facility Coordinator obtained a physician's order for all residents in the facility receiving 1:1 psychosocial therapy services from a 3rd party Licensed Certified Social Worker; specifically resident #5 and resident #6. Resident #4 has been discharged from the facility. On 07/02/25, the Social Services Director obtained a formal referral and informed the resident representative of the 1:1 psychosocial therapy services currently being provided by a Licensed Certified Social Worker to all residents currently receiving those services; specifically resident #5 and resident #6. Resident #4 has been discharged from the facility. 2) The facility has determined that all residents have the potential to be affected	7/24/25

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 658	Continued From page 14 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	F 658	by failure to obtain a formal referral and physician's order for ongoing psychosocial therapy services. 3) A 100% audit of the resident health record was conducted by the facility Coordinator on 07/02/25 to identify and ensure a referral and physician's order for all residents identified as receiving 1:1 psychosocial therapy services by a 3rd party provider. Facility identified eleven residents currently receiving 1:1 psychosocial therapy services, one resident has deceased, one resident was discharged from the facility, and the remaining eight completed therapy services. On 07/01/25, the Quality Assurance Committee met and reviewed the Physician Order Policy and approved with no revisions. On 07/01/25, the Quality Assurance Committee met and recommended development of a policy for mental health services referral. The Mental Health Services Referral Policy was developed and approved by the Quality Assurance Committee at that time. On 06/30/25, an in-service education program began by the Minimum Data Set (MDS) Coordinator, the Assistant Director of Nursing, and the facility Coordinator with all licensed nursing staff addressing referral procedures and the significance of ensuring services are provided and documented according to professional standards. In-servicing will continue until all licensed nursing staff have received the in-service education. A 1:1 in-service will be conducted by the facility Administrator and Coordinator for	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 658	Continued From page 15 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. 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	F 658	the Licensed Certified Social Worker providing psychosocial therapy services in the facility upon her return to the facility on or around 07/10/25 and prior to providing any further 1:1 psychosocial therapy services for the residents addressing the policy and procedures for mental health services referral, ensuring services are provided and documented according to professional standards, as well as, the Physician Order Policy. 4) Beginning 07/03/25, for a period of three months, the Social Services Director will audit all medical records weekly of residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker using the Mental Health Services Process Audit form to ensure a formal referral and physician's order has been obtained for all residents receiving 1:1 psychosocial therapy services by the Licensed Certified Social Worker. Corrective action will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly times three months beginning 07/23/25, and will continue until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Committee. The committee will make any recommendations or changes to ensure compliance.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 658	Continued From page 16	F 658		

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.

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 658	Continued From page 17 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.	F 658		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) 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, receives appropriate treatment and services to correct the assessed problem or to attain the highest	F 742		7/24/25

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 18 practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: 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	F 742	1) On 07/02/25, the Social Services Director obtained a formal referral for all residents receiving 1:1 psychosocial therapy services; specifically resident #5 and resident #6. Resident #4 has been discharged from the facility. 2) The facility has determined that all residents have the potential to be affected by failure to obtain a formal referral, have physician's oversight, and interdisciplinary coordination for ongoing psychosocial therapy services. A 100% audit of the resident health record was conducted by the facility Coordinator on 07/02/25 to identify and ensure formal referral, physician orders, and interdisciplinary coordination through comprehensive care plan revision for all residents identified as receiving 1:1 psychosocial therapy services by the 3rd party provider Licensed Certified Social Worker. Facility identified eleven residents currently receiving 1:1 psychosocial therapy services, one resident has deceased, one resident has been discharged from the facility and the remaining eight completed 1:1 psychosocial therapy services. 3) On 07/01/25, the Quality Assurance Committee met and recommended development of a policy for mental health services referral. The Mental Health Services Referral Policy was developed and approved by the Quality Assurance Committee at that time. The Quality Assurance Committee reviewed the	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 19 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.	F 742	Dementia and Behavioral Health Services Policy during this meeting on 07/01/25 and approved the policy with no revisions at that time. On 06/30/25, an in-service education program began by the Minimum Data Set (MDS) Coordinator, the Assistant Director of Nursing, and the facility Coordinator with all licensed nursing staff addressing the significance of identifying, assessing, and coordinating behavioral health services. In-servicing will continue until all licensed nursing staff have received the in-service education. A 1:1 in-service will be conducted by the facility Administrator and Coordinator for the Licensed Certified Social Worker providing psychosocial services in the facility upon her return to the facility on or around 07/10/25 and prior to providing any further 1:1 psychosocial therapy services addressing the significance of identifying, assessing, and coordinating behavioral health services, the policy and procedures for mental health services referral, and the Dementia and Behavioral Health Services Policy. 4) Beginning 07/03/25, for a period of three months, the Social Services Director will audit all medical records weekly of residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker using the Mental Health Services Process Audit form to ensure a formal referral has been obtained and interdisciplinary coordination for all residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker. Corrective action	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 20 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	F 742	will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly times three months beginning 07/23/25, and will continue until such time consistent substantial compliance has been determined by the Quality Assurance Committee. The Quality Assurance Committee will make any recommendations or changes to ensure compliance.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 21	F 742		

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

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 22	F 742		

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

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 742	Continued From page 23 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.	F 742		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		7/24/25

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 24	F 842		

to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 25 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: 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	F 842	1) To ensure complete and readily accessible medical records, on 07/02/25 the Social Services Director obtained a formal referral for all residents receiving 1:1 psychosocial therapy services; specifically, resident #5 and resident #6. Resident #4 has been discharged from the facility. On 07/01/25, the facility Coordinator obtained physician orders for all residents receiving 1:1 psychosocial therapy services; specifically, resident #5 and resident #6. Resident #4 has been discharged from the facility. On 07/01/25, the Minimum Data Set (MDS) Coordinator revised the comprehensive care plan to include care and services provided to meet the resident's psychosocial needs for all residents receiving 1:1 psychosocial	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 26 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	F 842	therapy services; specifically, resident #5 and resident #6. Resident #4 has been discharged from the facility. 2) The facility has determined that all residents have the potential to be affected by failure to maintain complete and readily accessible medical records. A 100% audit of the resident medical record was conducted by the facility Coordinator on 07/02/25 to identify and ensure a complete and readily accessible medical record to include formal referral, physician notification and order, resident representative notification, and care planning for all residents identified as receiving 1:1 psychosocial therapy services by the 3rd party provider Licensed Certified Social Worker. Facility identified eleven residents currently receiving 1:1 psychosocial therapy services, one resident has deceased, one resident has discharged from the facility, and the remaining eight completed 1:1 psychosocial therapy services. 3) The Dementia and Behavioral Health Services Policy was reviewed by the Quality Assurance Committee on 07/01/25 and approved with no revisions at that time. During the 07/01/25 Quality Assurance Committee meeting, the Committee recommended development of a policy for mental health services referral, and a mode of documentation to be completed by the Licensed Certified Social Worker in the resident medical record for each psychosocial therapy visit. The Mental Health Services Referral Policy and the LCSW Visit Note was developed and approved by the Quality	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 27 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 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,	F 842	Assurance Committee at that time. On 06/30/25, in-servicing began by the Minimum Data Set (MDS) Coordinator, Assistant Director of Nursing, and the facility Coordinator with all licensed nursing staff addressing the significance of maintaining complete, accurate and readily accessible medical records; review of the Mental Health Services Referral Policy; the Dementia and Behavioral Health Services Policy; and the assessment to be completed in the resident's medical record by the Licensed Certified Social Worker to document the reason for the visit, diagnosis, plan or recommendations. In-servicing will continue until all licensed nursing staff have received the in-service. The Licensed Certified Social Worker will be educated through 1:1 in-service by the facility Administrator and Coordinator regarding this information upon her return to the facility on or around 07/10/25 and prior to providing any further 1:1 psychosocial therapy services for the residents. 4) Beginning 07/03/25, for a period of three months, the Social Services Director will audit all medical records of residents receiving 1:1 psychosocial therapy services from the Licensed Certified Social Worker weekly using the Mental Health Services Process Audit form to ensure a formal referral has been obtained and interdisciplinary coordination for all residents receiving 1:1 psychosocial therapy services by the Licensed Certified Social Worker. Corrective action will be taken at the time for any issues identified.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 28 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	F 842	Audit reports will be reviewed by the Quality Assurance Committee monthly times three months beginning 07/23/25, and will continue until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Committee. The Quality Assurance Committee will make any recommendations or changes to ensure compliance.	

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 _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVE LAUREL, MS 39440

(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 842	Continued From page 29	F 842		

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.