

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/06/2026	
NAME OF PROVIDER OR SUPPLIER MCCOMB COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 415 MARION AVE P. O. BOX 1688, MCCOMB, Mississippi, 39648			
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M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #2793412, which was a Facility Reported Incident (FRI), at the facility on 3/6/26. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI MS #2793412 related to a resident who was found unresponsive and did not receive Cardiopulmonary Resuscitation (CPR). On 3/2/26 at 5:20 AM, Resident #1, who had a Full Code status, was found to be unresponsive and without a pulse or respirations. The nurse failed to check the residents' code status because he was in hospice services. Therefore, the nurse did not initiate CPR or activate emergency services for Resident #1. The facility's failure to review the code status resulted in Resident #1 not receiving CPR and emergency services. The resident subsequently expired at the facility. During the investigation, the SA identified an Immediate Jeopardy (IJ) on 3/2/26 and existed at: Rule 45.17.2 Resident Rights- M500- Level IV This situation placed Resident #1 and all other residents who were full code status at risk for serious harm, serious injury, serious impairment, or death. The SA notified the facility's Administrator of the IJ on 3/6/26 at 1:45 PM. Based on the facility's implementation of corrective actions on 3/3/26, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 3/4/26 prior to the SA's entrance on 3/6/26.		M0000				
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:		M0500	"Past Noncompliance - no plan of correction required"			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0500	Continued from page 1 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident 's choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to	M0500					

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M0500	Continued from page 2 facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M0500					

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M0500	Continued from page 3 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on policy review, record review and interviews the facility failed to provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to a resident requiring such care or initiate the emergency response system in accordance with related physician's orders and the resident's advance directives for one (1) of four (4) sampled residents. Resident #1 The facility's failure to review and implement the code status according to the advance directives resulted in Resident #1 not receiving CPR and emergency services. The resident subsequently expired at the facility. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 3/2/26 and existed at: 42 CFR(s): 483.24 (a)(3) -Cardiopulmonary Resuscitation (F678) Scope and Severity "J".		M0500				

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M0500	Continued from page 4 This situation placed Resident #1 and all other residents who were full code status at risk for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/6/26 at 1:45 PM and provided the IJ template. The facility provided an acceptable corrective action plan on 3/6/26 in which they alleged all corrective actions to remove the IJ were completed on 3/3/26 and the IJ removed on 3/4/26. Based on the facility's implementation of corrective actions on 3/3/26, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 3/4/26 prior to the SA's entrance on 3/6/26. Findings Included: Record review of the facility policy titled, "Emergency Procedure-Cardiopulmonary Resuscitation" version date April 2, 1998, revealed, "... If an individual (resident, visitor or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or b. There are obvious signs of irreversible death (e.g., rigor mortis) ...Emergency Procedure-... If an individual is found unresponsive, briefly assess for abnormal or absence of breathing...b. Instruct a staff member to activate the emergency response system (code) and call 911...c. Verify or instruct a staff member to verify the DNR or code status of the individual. d. Initiate the basic life support (BLS) sequence of events...chest compressions, airway, breathing..." Record review of the "RESIDENT/FAMILY CONSENT FOR CARDIOPULMONARY RESUSCITATION" dated 1/23/26 for Resident #1 and signed by Resident #1's Resident Representative (RR) revealed the document indicated by initials of the RR stated, "I understand that CPR constitutes an extraordinary measure and SHOULD be done on this resident in care of extreme emergency". Record review of the Progress Notes for Resident #1 dated 3/02/26 at 5:47 AM, revealed Licensed Practical Nurse (LPN) #1 documented on 3/02/26 she observed the resident was not breathing and she was unable to obtain any vital signs and documented that in response she notified a hospice nurse, the resident's primary healthcare provider and Resident Representative (RR), the Director of Nurses (DON) and the Executive Director (ED), with no mention of initiation of cardiopulmonary		M0500				

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M0500	Continued from page 5 resuscitation. Record review of the incident Report dated 3/03/26 revealed that on 3/02/26, "Resident was found unresponsive at approximately 5:20 am by the CNA. The CNA reported to the nurse resident condition. The nurse went to the Resident room and found the resident in his bed unresponsive. She attempted to obtain a pulse and blood pressure without success and did not observe any rise or fall of his chest." Record review of the Facility Investigation revealed LPN #1 observed Resident #1 was not responsive at 5:20 AM on 3/02/26 and did not verify the resident's code status and did not initiate the emergency response system or CPR. On 3/06/26 at 1:20 PM, during a telephone interview LPN #1 revealed that at approximately 5:20 AM on 3/02/26 she observed Resident #1 was not responsive. She said she left his room, gathered equipment to measure vital signs, returned and was unable to attain any detectable pulse and Resident #1 had no chest rise or fall and she was unable to auscultate any breath sounds with stethoscope. She stated that she left him again and "grabbed his binder" at the nurses' station to locate the telephone number for his hospice service and notified the on-call hospice nurse that he had died. She stated that she was notified by the DON on 3/03/26 that Resident #1 had a code status of "Full Code". LPN #1 stated, "I didn't run a code due to him being hospice. I always worked with hospice patients that were DNR code status." She confirmed that when she "grabbed" the resident's binder (or chart) she did not look for his code status. She confirmed that she did not look on Point Click Care (PCC) software for the resident's code status and that she got his binder (chart) to look for the telephone number for his hospice service. On 3/06/26 at 1:25 PM, during an interview the ED said she was notified on 3/03/26 by the night shift (11:00 PM to 7:00 AM) Nurse Supervisor of an allegation that proper emergency procedure for an unresponsive resident was not initiated when Resident #1 was determined to be unresponsive by LPN #1 on 3/02/26. She confirmed that she notified the DON of the allegation on 3/03/36 at 7:28 AM. She said an investigation was immediately initiated, beginning with record review of the medical record for Resident #1 and subsequent interview with LPN #1. The ED confirmed that the facility investigation determined that LPN #1 had failed to follow the correct protocol for an incidence of an unresponsive resident on 3/02/26 because she failed to			M0500			

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M0500	Continued from page 6 check Resident #1's code status after determining he was nonresponsive and pulseless and failed to initiate the proper emergency procedure for an unresponsive resident. She confirmed that facility policy was that any incident of a resident being nonresponsive should result in their nurse checking, or having another staff check, the resident's code status. She confirmed that failure to check a resident's code status and that failure to initiate the emergency CPR procedure for a resident with 'Full Code' code status during an unresponsive episode could result in lack of provision of potentially lifesaving interventions. On 3/06/26 at 1:30 PM, during an interview the Director of Admissions revealed each resident's code status was printed on the Admission Record (the first item in each resident's binder/chart) and under the Advanced Directives tab behind the Admission Record. She said there would also be a Physician's Order if the resident requested DNR. She confirmed the code status was visible on each resident's Electronic Medication Administration Record (EMAR) available to nurses. She stated that just because the resident received hospice services did not mean they automatically had a DNR code status. Record review of the "Order Summary Report" revealed an order dated 6/3/25 for code status "Full Code", which indicated the resident had chosen to receive cardiopulmonary resuscitation in case of cardiac arrest or pulselessness. Record review of a handwritten "Physician's Telephone Orders" dated 11/18/25 revealed an order to admit to hospice with a code status listed as "Full Code." Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 6/03/25 with diagnoses of severe protein-calorie malnutrition, heart failure and atherosclerotic heart disease. Record review of the Minimum Data Set (MDS) for Resident #1 with Assessment Reference Date (ARD) 2/18/26 revealed the resident's Brief interview for Mental Status (BIMS) score was listed as 99 with documentation that the resident was unable to complete the interview, with no noted memory problem and was independent with decisions regarding tasks of daily life. Section 0 of the MDS review revealed the resident received hospice care. Corrective Action Plan Resident (#1) who was receiving hospice services from		M0500				

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M0500	Continued from page 7 Hospice Compassus beginning on November 18, 2025, for unspecified severe protein calorie malnutrition, unspecified systolic congestive heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, personal history of malignant neoplasm of the prostate, and dysphasia unspecified. Resident has resided at McComb Community Care Center since June 3, 2025, and was listed as a full code per the resident/family request on June 3, 2026. The resident expired on March 2, 2026, at approximately 5:20am with no CPR initiated. Coroner, RP, DON, Administrator and Hospice were notified of the death. On 03/03/2026 the resident's assigned nurse was suspended pending the results of the investigation. On 03/03/2026 the QA Committee completed a root cause analysis to identify the cause of the failure to initiate CPR. QA Committee has reviewed the "Emergency Care", "Resident Rights", "Abuse-Neglect of Resident" and "Care Plans, Comprehensive Person-Centered" policies, and identified that no updates are required. On 03/03/2026 nursing staff education was initiated regarding the "Emergency Care" policy prior to working until 100% of nursing staff education has been achieved. Nurses will not be allowed to work without in-servicing on the "Emergency Care" Policy. Training was initiated on Emergency Care/Code Status utilizing a Mock code with the clinical team beginning on 03/03/2026 by the Director of Nursing (DON). Post training debriefing will be completed by the DON or the Staff Development Nurse to evaluate learning 100% of residents' medical records were audited on 03/03/2026 for accuracy of correct code status by the Medical Records Nurse. No residents were affected. DON, ADON or the Staff Development Nurse will continue to conduct mock codes with debriefing to evaluate learning twice a week for 12 weeks. The QA Committee will review results of debriefing and evaluation of learning and make recommendations on any adjustments to the plan of correction. An Emergency QA Meeting was conducted on 03/03/2026 to discuss with the interdisciplinary team members and the Medical Director the results of the findings and the plan of action. The facility alleges all corrective actions were completed on March 3, 2026, and the IJ removed on March			M0500			

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M0500	Continued from page 8 4, 2026. Validation: The SA validated the Corrective Action Plan on 3/06/26 and determined the IJ was removed on 3/04/26 prior to SA entrance on 3/06/26.			M0500			