MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS 20286 at the facility on 1/03/23. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA substantiated the complaint for Misappropriation of resident property and cited M500. Based on the facility's implementation of corrective actions on 12/21/22, this was determined to be Past Non-Compliance.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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	M 500		1/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 1 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 2	M 500		

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 3 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); 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 Statute is not met as evidenced by: Level II Past Non Compliance Based on record review, interviews, and facility policy review, the facility failed to prevent the misappropriation of property for one (1) of four (4) residents reviewed for misappropriation of	M 500	Due to the deficiency being sited as past non-compliance a plan of correction is not necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 4	M 500		

property. Based on implementation of the facility's corrective actions on 12/21/22, this was determined to be Past Non Compliance. Resident #1

Findings include:

Record review of the facility's policy, "Abuse Prevention," with a revision date October 2022, revealed ... "The facility is committed to protecting the residents from abuse ...Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent ... Exploitation: Taking advantage of a resident for personal gain through the use of manipulations, intimidation, threats or coercion... Mistreatment means inappropriate treatment or exploitation of a resident..."

Review of facility's document entitled, "Vulnerable Adults in Mississippi," undated, revealed ... "What is a Vulnerable Adult?... includes all residents or patients, regardless of age, in a care facility ...It shall be unlawful for any person to abuse, neglect or exploit any vulnerable adult ..."

Record review of the facility "Supervisor Investigation Summary Form," dated 12/23/22, and signed by the Executive Director (ED) revealed, "On December 21, 2022, the Resident (Resident #1) reported to a Certified Nursing Assistant (CNA) that he gave a CNA his debit card to buy him (Proper Name) Chicken and the CNA spent his money ...On December 21, 2022, during interview with the ED, Director of Nursing (DON), and Social Service Director (LSW), the Resident (Resident #1) stated that on November 25, 2022, he gave (proper name) CNA #1 his debit card to purchase chicken for him from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 5	M 500		

(Proper Name) Restaurant. He stated that she brought him the chicken but that she did not return his debit card and she still had the debit card. The Resident confirmed that he had willfully given the CNA (CNA #1) his debit card but stated that the CNA had spent $450 from his bank account without his permission." Further details within the facility investigation reveal the ED called CNA #1 and requested that she come to the facility to meet the ED and DON to discuss an issue. As the CNA #1 did not come to the facility, the ED called the CNA again and was told that CNA #1 revealed that she did not have a babysitter and would not be able to come to the facility. It was at that time that the ED informed CNA #1 that the DON was in the room and asked the CNA questions about using the Resident #1's debit card to purchase the Resident chicken from (Proper Name) Restaurant. CNA #1 confirmed that she had purchased the chicken, but she had returned the debit card to Resident #1. CNA #1 stated that Resident #1 said she owed him $450, and she told him that she would pay him back on Friday, even though she didn't spend his money. She further stated that she didn't spend his money but since she was the last one who had his card, she was going to make it right even though it was causing a hardship on her. At this time, the investigation revealed that the ED reviewed the purchases on Resident #1's bank statement that he provided to the ED. CNA #1 verbally confirmed making the purchases but stated that Resident #1 consented to the purchases. The ED asked CNA #1 what the facility's policy said regarding using resident funds, and the CNA replied "we ain't suppose to." Following this statement, the investigation revealed that the ED informed the CNA that she was being terminated for violation of Resident Rights. The facility investigation of the alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 6	M 500		

incident also revealed that the ED notified the (Proper Name) Police Department of the allegation on December 21, 2022, at approximately 9:00 AM. When the (Proper Name) Police Officer arrived at the facility at approximately 1:40 PM, the ED was present during his interview with the Resident #1. The ED recorded in investigation that the Police Officer informed the Resident that he could not take a police report because the Resident willingly gave the CNA his debit card to purchase food for him. The last portion of the investigation revealed that on December 23, 2022, the ED calculated the total amount of the debit card transactions and submitted a check request to the facility Accounts Payable Department in the amount of $419.65 to refund the money to Resident #1.

Record review of the personnel file for CNA #1 confirmed her employment at the facility was terminated effective 12/21/22, for violation of facility policies.

Record review of the Face Sheet for Resident #1 revealed he had been admitted by the facility on 4/01/22, with an admitting diagnosis of Encounter for Orthopedic Aftercare. Resident #1 also had diagnoses including Cervical Disc Disorder with Myelopathy, Diabetes, and Anemia.

Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date 10/11/22, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.

On 1/03/23, at 12:40 PM, in an interview with Resident #1, he did not state that he had willingly given CNA #1 his debit card to purchase chicken. Resident #1 explained he knew he had his debit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 7	M 500		

card on Thanksgiving Day (11/24/22) because he had gone to Thanksgiving dinner at the home of his son and used the debit card on the return drive to the facility to put gas in his son's car. He revealed during his Thanksgiving visit at his son's home, he had gotten sick and had gone to bed immediately upon return to the facility. He stated he must have left his card on his over-the-bed table. He stated that the following day, CNA #1 visited him in his room and inquired about his Thanksgiving. He stated, "I guess that's when she got it." He said he initially thought he had lost his card and checked with a laundry worker to see if he had left his card in his pants pocket, but she told him she had not seen it. He stated when he called the bank, they told him his card "had been used a lot." Resident #1 confirmed that the bank canceled his debit card and issued him a new one. Resident #1 also revealed that when the Police Officer came to the facility, the officer told him that he would need to go to the police station to make an official report. Resident #1 confirmed that a family member had assisted him with doing so, but said he did not have a copy of the police report. Resident #1 stated he had not seen CNA #1 since he discovered the money missing from his bank account.

On 1/03/22 at 2:15 PM, an interview with the facility Social Worker Director revealed he became aware of the alleged abuse when the ED asked him if he was aware of the abuse on the morning of 12/21/22. The Licensed Social Worker/Director (LSW) stated he attended a conference on the morning of 12/21/22 with the ED and Resident #1, during which time, Resident #1 reported that CNA #1 had his debit card and had taken approximately four hundred and fifty dollars ($450.00) out of his account without his permission. The LSW stated, "No staff is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 8	M 500		

supposed to take any resident's debit or credit card for any reason."

On 1/03/23 at 3:16 PM, a telephone interview with the Responsible Representative (RR) for Resident #1 revealed he had been notified of the incident of misappropriation but could not recall when. He confirmed that Resident #1 was very independent and took care of his own business. He said he did not have any information to add but confirmed that he had been made aware of the incident.

On 1/03/23 at 3:30 PM a telephone interview with CNA #2 revealed she said that between 8:00 AM and 8:30 AM on 12/21/22 Resident #1 had disclosed to her that CNA #1 had taken his debit card and made several transactions, however, she stated she was not sure of the amount spent. CNA #2 explained she immediately reported the allegation to the facility ED and provided a written statement.

On 1/03/23 at 5:20 PM an interview with Laundry Aide #1 revealed she reported Resident #1 came to her while she was in the hallway on 11/25/22, asking if she had seen his debit card. She stated that she had told Resident #1 that she had not seen his card but went with the resident to his room to assist him in searching for his card, but they had been unable to locate the card.

On 1/03/23 at 5:28 PM an interview with RN #1 revealed she stated that she was familiar with Resident #1 and had never observed him in a state of confusion or disorientation.

On 1/03/23 at 6:05 PM during an interview with the ED, she revealed as the facility Abuse Coordinator, she had served as the lead

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57SE	A. BUILDING: _____ B. WING _____	C 01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 9 investigator of the incident. She confirmed as soon as she had been notified of the incident on 12/21/22, she began the investigation and notified the (Proper Name) Police Department, the Attorney General's Office (AGO) and the State Agency. The ED provided a copy of the reimbursement check in the amount of $419.65 paid to the order of Resident #1. The SA validated through record review and staff interview the in-service training regarding Abuse, Neglect, Misappropriation and Exploitation Prevention and Reporting was provided on 12/21/22. The SA valided through interview on 1/3/23 with the ED that the Quality Assurance and Assessment (QAA)Committee received the results of the investigation for the allegation on 12/22/22.	M 500		