

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 08/06/2026	
NAME OF PROVIDER OR SUPPLIER MCCOMB COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 415 MARION AVE , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
M0000	Initial Comments		M0000				
	The State Agency (SA) conducted an Annual Recertification survey along with two (2) Complaint Investigations (CI MS #3028896 and CI MS #3050974) at the facility from 8/3/26 through 8/6/26. The SA investigated CI MS # 3028896 for environment and activities of daily living. CI MS # 305974 was investigated for staffing. There were no citations related to the complaint investigations. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610 and M1570.						
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility policy review and record review, the facility failed to provide oral care according to physician orders for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL) care. Resident #52. Findings include: Record review of the facility policy, "Mouth Care" revised February 2018 revealed, " The purposes of this procedure are to keep the resident's lips and		M0610				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0610	Continued from page 1 oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection..." Record review of the facility policy "Resident Rights" revised December 2016 revealed, "...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to... a dignified existence; b. be treated with...dignity..." On 8/3/26 at 2:30 PM, Resident #52 was observed with visibly unclean teeth. Dried secretions, dried skin, and a thick white film were observed on the residents' teeth. On 8/5/26 at 9:22 AM, Resident #52's mouth was again observed to be visibly unclean. The resident had unclean teeth, thick oral secretions, and visible plaque on the teeth During an interview on 8/5/26 at 9:45 AM, Licensed Practical Nurse (LPN) #3 stated she had applied lip balm to Resident #52's lips that morning. LPN #3 stated staff cleaned the resident's mouth daily but acknowledged the resident's mouth had appeared this way since admission. During an interview on 8/5/26 at 11:07 AM, Certified Nursing Assistant (CNA) #1 stated CNAs were responsible for cleaning Resident #52's mouth daily. CNA #1 stated she completed the resident's oral care at approximately 10:00 AM that morning. CNA #1 stated she was unsure whether the night-shift staff consistently provided oral care because she worked the 3:00 PM to 11:00 PM shift. During an interview on 8/5/26 at 12:50 PM, the Director of Nursing (DON) confirmed Resident #52's mouth appeared visibly unclean that morning. The DON stated the resident's mouth was chronically covered with plaque, although the amount varied and improved when staff cleaned the resident's mouth. The DON confirmed oral care was not documented as completed on 7/26/26, 8/2/26, and 8/4/26. The DON stated CNAs were responsible for providing oral care twice daily. The DON stated she did not know why staff failed to provide the care on the identified dates. The DON stated failing to provide oral care could result in plaque buildup, cavities, and an increased risk of infection. The DON stated she expected CNAs to provide oral care twice daily and licensed nurses to intervene when CNAs did not provide the required care. The DON also stated the facility sent Resident #52 to a dentist during	M0610					

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M0610	Continued from page 2 September 2025, but the dentist did not evaluate the resident because of an insurance or payment dispute. A review of the "Oral Care Task Record" for Resident #52 revealed oral care was not completed on 7/26/26, 8/2/26, and 8/4/26. A review of resident # 52's "Admission Record" revealed she was admitted on 6/20/24 with a diagnosis of aphasia following cerebral infarction. A review of resident #52's "Order Summary Report" revealed an order for Enteral Feed Order every shift Nasal/Oral Care dated 6/27/26. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/26 revealed a Brief Interview of Mental Status (BIMS) score of three (3) indicating cognitive skills were severely impaired.		M0610				
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.		M1570				

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M1570	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to follow hand hygiene and infection prevention practices for two (2) of three (3) care observations. Resident #3 and #95 Findings include: Record review of the facility policy "Handwashing/ Hand Hygiene" with a revision date of 08/2015 revealed, "The facility considers hand hygiene the primary means to prevent the spread of infections... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors..." Resident #3 On 8/5/26 at 10:05 AM, Certified Nursing Assistant (CNA) #2 was observed providing urinary catheter care to Resident #3. CNA #2 gathered supplies, donned a gown, and entered the resident's room. CNA #2 filled a basin with warm water and applied gloves. While wearing the gloves, CNA #2 pulled back the resident's bed covers, adjusted the bed, and touched the privacy curtain before beginning catheter care. Resident #3 had feces in the brief. During care, CNA #2 removed her gloves and applied clean gloves on two occasions without performing hand hygiene. CNA #2 did not perform hand hygiene before beginning care, between glove changes, or after completing care. During an interview on 8/5/26 at 10:38 AM, CNA #2 confirmed she did not perform hand hygiene before, during, or after Resident #3's catheter care. CNA #2 stated she forgot. CNA #2 acknowledged that failing to perform hand hygiene while providing catheter care could cause the resident to develop an infection. A review of Resident #3's "Admission Record" revealed an admission date of 3/24/25 with diagnoses that included neuromuscular dysfunction of the bladder and urinary tract infection. A review of Resident #3's "Order Summary Report" revealed an order dated 7/17/26 for an 18 French, 30 cubic centimeter indwelling urinary catheter and catheter care with soap and warm water every shift. A review of Resident #3's Minimum Data Set (MDS)	M1570					

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M1570	Continued from page 4 with an Assessment Reference Date (ARD) of 5/27/26, revealed the resident was severely cognitively impaired. Resident #95 On 8/5/26 at 8:00 AM, Licensed Practical Nurse (LPN) #2 was observed administering medication to Resident #95. LPN #2 gathered supplies and gloves, knocked on the resident's door, and entered the room. LPN #2 applied gloves and administered one drop of latanoprost ophthalmic solution into each of the resident's eyes. LPN #2 did not perform hand hygiene upon entering the room or before applying gloves and administering the medication. During an interview on 8/5/26 at 8:30 AM, LPN #2 acknowledged she made a mistake and failed to perform hand hygiene before administering Resident #95's ophthalmic medication. LPN #2 stated she usually performed hand hygiene before administering medication. LPN #2 acknowledged that failing to perform hand hygiene could cause the resident to develop an eye infection. A review of Resident #95's "Admission Record" revealed an admission date of 5/20/25 with a diagnosis that included unspecified glaucoma. A review of Resident #95's "Order Summary Report" revealed an order dated 3/16/26 for latanoprost ophthalmic solution 0.005 percent, one drop in each eye once daily for glaucoma. A review of Resident #95's MDS with an ARD of 5/1/26, revealed a Brief Interview for Mental Status score of 9, which indicated moderate cognitive impairment. During an interview on 8/6/26 at 12:58 PM, the Infection Preventionist stated LPN #2 should have performed hand hygiene upon entering the resident's room and before administering the ophthalmic medication and CNA #2 should have performed hand hygiene upon entering the resident's room and between glove changes. The Infection Preventionist stated the failure created cross-contamination and the possibility of spreading infection. She stated she expected staff to follow the facility's infection prevention policies and procedures. During an interview on 8/6/26 at 1:37 PM, the Director of Nursing (DON) stated CNA #2 should have performed hand hygiene before beginning care and each time she changed gloves, and she			M1570			

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M1570	Continued from page 5 expected LPN #2 to perform hand hygiene upon entering the resident's room and before applying gloves and administering medications or treatments. The DON stated she expected staff to provide care according to facility procedures and their training.		M1570				