

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Coastal Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 Broad Ave Gulfport, MS 39501	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41306 Based on staff interview, record review, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for a resident with an unhealed pressure ulcer for one (1) of three (3) residents sampled residents. (Resident #1) Findings Include: A review of the facility's policy titled MDS, revised 9/25/2017, revealed: .The center conducts initial and periodic standardized comprehensive and reproducible assessments no less than every three months for each resident .using the federal and/or state-required RAI (Resident Assessment Instrument) Each person completing a section or portion of a section of the MDS signs .indicating accuracy . A record review of the Admission Record revealed that the facility admitted Resident #1 on 09/07/24 with diagnoses including Osteomyelitis. A record review of the Order Summary Report revealed Resident #1 had a wound care order for his sacrum that was dated 07/03/24. A record review of the Comprehensive MDS for Resident #1, with an Assessment Reference Date (ARD) of 07/15/24, revealed Section M0210 indicated Resident #1 did not have a PU. A record review of the Weekly Observation Tool for Resident #1 revealed that on 07/03/24, a sacral pressure ulcer was present. There was no other weekly wound documentation until 8/9/24. On 10/01/24 at 1:13 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed that there had been a significant change in Resident #1's condition on 07/15/24 due to the resident receiving dialysis. She explained the wound had not been addressed on the comprehensive MDS because there was no weekly wound report in the medical record that corresponded with the lookback period. On 10/02/24 at 1:10 PM, during an interview, the Interim Director of Nursing (I-DON) stated that if charting and wound assessment tools were not completed in the resident's chart, then the information could not be captured correctly on the MDS. She confirmed that the MDS with an ARD of 7/15/24 for Resident #1 did not accurately reflect that he had a PU.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306 Based on interviews, record review, and facility policy review, the facility failed to implement care plan approaches or interventions related to wound care for three (3) of four (4) sampled residents. Resident #1, Resident #3, and Resident #4. The failure to implement care plan interventions resulted in Resident #1 acquiring a wound infection with hospitalization . Resident #1, Resident #3, and Resident #4 Findings Include: A review of the facility's policy titled Plans of Care, with a revision date of 09/25/2017, revealed: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Resident #1: A record review of the Admission Record revealed that the facility initially admitted Resident #1 on 1/30/2017 and he had current diagnoses including Osteomyelitis. A record review of the Order Summary Report revealed Resident #1 had a physician's order, dated 07/03/24, to cleanse the sacrum with wound cleanser, pat dry, and gently apply Medihoney and secure with large foam dressing daily. A record review of Resident #1's Comprehensive Care Plan revealed a focus on impaired skin integrity. The interventions and tasks included: Cleanse sacrum with wound cleanser, pat dry, gently apply Medihoney, and secure with large foam dressing daily. A record review of Resident #1's Electronic Treatment Administration Record (E-TAR) for July 2024 revealed that wound care was not documented as completed on ten (10) of 28 days: July 7, 8, 10, 11, 12, 15, 20, 26, 27, and 30. A record review of Resident #1's E-TAR for August 2024 revealed that wound care was not documented as completed on seven (7) of 21 days: August 2, 5, 6, 7, 8, 14, and 16. Resident #3: A record review of the Admission Record revealed that the facility admitted Resident #3 on 12/22/21 with diagnoses including Unspecified Injury to the Cervical Spine Cord and Paraplegia. Sacrum/Right Buttocks: A record review of Resident #3's Comprehensive Care Plan revealed a focus on a high risk for impaired skin integrity, with interventions and tasks including wound care for the sacrum and right buttocks daily. (continued on next page)		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	A record review of the Order Summary Report revealed a physician's order dated 06/26/24 to Cleanse sacrum and right buttocks with wound cleanser, pat dry gently, apply [NAME] cream to excoriated area, apply ABD (abdominal gauze) pads to cover areas, and secure with an adult diaper. No tape, daily. A record review of the E-TAR for July 2024 revealed wound care was not documented for Resident #3's sacral wound as completed on nine (9) out 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's sacral wound as completed for nine (9) of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, and 19. Left Heel: A record review of Resident #3's Comprehensive Care Plan revealed a focus on impaired skin integrity, with interventions and tasks for the left heel wound: Cleanse with wound cleanser, pat dry, cover with xeroform ABD pad, and secure with kerlix dressing daily A record review of the Order Summary Report dated 06/26/24 revealed orders for wound care for the left heel to be performed daily, as detailed above. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on nine (9) out of 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's left heel as completed for ten (10) out of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, 25, and 26. Right Heel: A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 8/12/24, for wound care daily. Further review revealed the physician's treatment order for the right heel was changed on 8/21/24 and 8/26/24. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's right heel as completed for: August 14, 15, 16, 17, 18, 25, and 26. Resident #4: A record review of the Admission Record revealed that the facility admitted Resident #4 on 08/07/23 with diagnoses including Type 2 Diabetes Mellitus. Right Heel: Record review of the Care Plan with a date initiated of 10/12/2023, revealed Focus: .has actual impairment to skin integrity .Interventions .Cleanse right heel with wound cleanser, pat dry, apply betadine-soaked 4x4, and cover with dry dressing. A record review of the Order Summary Report dated 05/21/24 revealed orders for wound care to the right heel, to be completed every other day, as detailed above. (continued on next page)		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days: July 7, 13, 21, 27, and 31. A record review of the E-TAR for August 2024 revealed that wound care was not documented as completed on three (3) out of 19 days: August 2, 14, and 25. Sacrum: A record review of the Comprehensive Care Plan revealed a focus on actual impairment to skin integrity, with interventions and tasks for the sacral wound: Cleanse sacral wound with wound cleanser, pat dry, apply barrier cream, and cover with dry dressing every 12 hours. A record review of the Order Summary Report dated 05/21/24 revealed a physician's order for wound care to the sacral wound, to be completed every 12 hours. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on eight (eight) days out of thirty-one (31) days, July 7, 13, 14, 21, 26, 27, 30, and 31. A record review of the E-TAR August 2024 revealed that wound care was not documented as completed on seven (7) out of nineteen (19), August 2, 5, 7, 9, 14, 17, and 25 On 09/25/24 at 12:30 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that care plans are developed to ensure individualized care and improve consistency in resident care. She added that as a manager of several halls in the facility, she expected all nursing staff to follow the care plans. On 09/25/24 at 1:00 PM, during an interview, the Interim Director of Nursing (I-DON) confirmed that wound care for Resident #1, Resident #3, and Resident #4 was not documented as completed on several occasion as per the care plan. She emphasized the importance of following the care plans for all residents, noting that the care plans provide a personalized and effective outline of care.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41306 Based on interviews, record review, and facility policy review, the facility failed to provide care and treatment in accordance with professional standards of practice, by failing to follow a Physician's Order to obtain a urinalysis and to administer an antibiotic medication promptly for one (1) of four (4) sampled residents observed. Resident #2. Findings Include: A review of the facility's policy titled Physician Orders, revised on 03/03/2021, revealed: .Policy: The center will ensure that physician orders are appropriately and timely documented in the medical record. A review of the facility's policy titled Laboratory Diagnostic and X-Ray, revised on 06/21/2021, revealed: . Policy: To provide guidance on ordering, obtaining, documenting and reporting laboratory, diagnostic, and x-ray results .Procedure .Document notification of the practitioner and resident/resident representative of results .Laboratory work, diagnostic testing .to be filed in the electronic medical record . A record review of the Admission Record revealed the facility admitted Resident #2 on 08/07/2024 with diagnoses including Metabolic Encephalopathy. A record review of the facility's Physician/Prescriber document revealed Resident #1 had a telephone Physician's Order received on 08/15/2024 at 6:00 PM for a Urinalysis (UA) with Culture and Sensitivity (C&S), given by a medical provider to Registered Nurse (RN) #1. A record review of the Order Summary Report revealed that on 08/17/2024, an order was received for Levaquin 750 milligrams (mg) daily for seven (7) days to treat a UTI (urinary tract infections). A record review of the Order Details for Resident #2 revealed the Physician's Order for Levaquin was entered into the electronic medical record at 2:15 PM on 8/17/2024. A record review of the medical record revealed there was no documentation indicating that a urine sample was collected and sent to the local laboratory on 8/15/24. Nor was there any documentation indicating laboratory results from a urinalysis in the medical record for Resident #2. During a phone interview on 09/23/2024 at 10:00 AM, Resident #2's daughter revealed that on 08/13/2024, she informed staff that her mother was complaining of burning with urination and requested a urine test be performed since her mother had a history of frequent UTIs. The daughter stated that she thought the urine test was done on 08/16/2024. She said there were new orders for antibiotics prescribed on 08/17/2024, however, she complained that the antibiotics were not started until 08/18/2024. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/2024 at 2:00 PM, Registered Nurse #1 confirmed that on 08/15/2024 at 6:00 PM, he received a phone order from the medical provider for Resident #2 to have a urine test with C&S late on 8/15/24. He stated that he informed his supervisor, who was responsible for obtaining the urine sample and taking it to the local hospital. However, RN #1 admitted that he did not follow up with the supervisor or other nursing staff to ensure the test was completed. During an interview on 09/26/2024 at 9:00 AM, the Interim Director of Nursing (I-DON) confirmed there was a delay in treatment for Resident #2 because the urine test, ordered on 08/15/2024, should have been collected and sent to the local hospital promptly. The I-DON also called the lab during the survey to request a copy of the U/A results, however, the lab did not have a record that the urine sample was received. She also confirmed that when the antibiotic order was received on 08/17/2024, the medication should have been administered from the facility's Omnicell (automated dispensing cabinet) the same day instead of being delayed until 08/18/2024. On 09/26/2024 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #1/Supervisor she confirmed RN #1 advised her of the order for Resident #2 on 08/15/2024, and she had instructed another nurse to collect the urine sample and take it to the local hospital. She explained the nurse no longer worked for the facility. She stated she did not follow up to ensure the urinalysis was collected or that the results were obtained. LPN #1 explained that when the antibiotic was prescribed for Resident #2 on 08/17/2024, it should have been administered that day because the medication was available at the facility. LPN #1 acknowledged that there was a delay in treatment, as the medication was not given until 08/18/2024. On 09/26/2024 at 10:00 AM, during an interview, the Nurse Practitioner (NP) stated that although the urine test results were not available, she went ahead and prescribed a broad-spectrum antibiotic, Levaquin, on 08/17/2024 while awaiting the results of the culture and sensitivity, which can take several days to receive. The NP confirmed that she expected the facility to administer the antibiotic the day it was ordered. During an interview on 09/26/2024 at 11:00 AM, the Administrator confirmed that the urine test and the antibiotic medications should have been completed on the days they were ordered by the prescriber. On 09/26/2024 at 11:30 AM, during an interview with the Infection Preventionist (IP), she confirmed that she worked part-time at the facility and that all supervisors assist with the antibiotic stewardship program. The IP further confirmed that the urine test should have been collected on 08/15/2024 and sent to the local laboratory, and the antibiotic prescribed on 08/17/2024 should have been administered without delay. Not giving the antibiotic until 08/18/2024 constituted a delay in treatment for Resident #2.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41306 Based on interviews, record review, and facility policy review, the facility failed to ensure residents received consistent pressure ulcer (PU) care and treatment, for three (3) of three (3) residents reviewed for wounds, Resident #1, Resident #3, and Resident #4, and resulted in Resident #1 acquiring a wound infection with hospitalization . Findings Include: A review of the facility's policy titled Skin and Wound, revised 01/24/2021, revealed, .To provide a system for identifying risk and implementing resident-centered interventions to promote skin health, prevention, and healing of pressure injuries .Skin Impairment Identification: 1. Document presence of skin impairment(s)/new skin impairment(s) when observed . Resident #1: A record review of the Order Summary Report revealed Resident #1 had a physician's order, dated 07/03/24 for wound care to the sacrum daily. A record review of Resident #1's Electronic Treatment Administration Record (E-TAR) for July 2024 revealed that wound care was not documented as completed on ten (10) of 28 days: July 7, 8, 10, 11, 12, 15, 20, 26, 27, and 30. A record review of Resident #1's E-TAR for August 2024 revealed that wound care was not documented as completed on seven (7) of 21 days: August 2, 5, 6, 7, 8, 14, and 16. A record review of the Wound-Weekly Observation Tool revealed the facility had documented Resident #1's PU to the sacrum on 07/03/24 and again on 08/09/24, which was a significant gap in weekly wound documentation. The facility failed to perform weekly wound assessments or documentation, including wound measurements, characteristics, and progression of the sacral wound for the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. A record review of the Progress Note Details, dated 7/3/24, indicated the Nurse Practitioner (NP) assessed Resident #1 for an Initial Wound Evaluation for the PU to the sacral region. The NP followed up with the sacral wound on 8/21/24 and determined the wound was deteriorating and recommended the resident be sent out for possible surgical debridement due to deterioration and odor. A record review of the History and Physical documentation from a local hospital, dated 08/21/24, revealed Resident #1 had a History of Present Illness listed as Sepsis, sacral wound infection .Assessment/Plan Goals indicated Resident #1 had sepsis and the source was listed as sacral wound infection, stercoral colitis, possible UTI (Urinary Tract Infection) .Status post excisional debridement on 8/26/24 by general surgery . Further review revealed he was discharged from the local hospital on 09/04/24. A record review of the Admission Record revealed that the facility initially admitted Resident #1 on 1/30/2017 and he had current diagnoses including Osteomyelitis. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #3: Sacrum/Right Buttocks: A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 6/26/24, for wound care daily. Further review revealed the physician's treatment order for the right buttocks/sacrum was changed on 8/26/24 for continued wound care daily. A record review of the E-TAR for July 2024 revealed wound care was not documented for Resident #3's sacral wound as completed on nine (9) out 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's sacral wound as completed for nine (9) of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, and 19. A record review of the Wound-Weekly Observation Tool revealed the facility had documented on 7/4/24 that Resident #3 had Moisture Associated Skin Damage (MASD) to the right buttocks/sacrum. The facility's next weekly wound documentation occurred on 8/13/24 in which the area was identified as a diabetic/ischemic wound and created a significant gap in documentation. The facility failed to perform weekly assessments or document wound measurements and progression for the sacral/right buttocks wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, 08/04/24, and 08/18/24. Left Heel: A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 6/26/24, for wound care daily. Further review revealed the physician's treatment order for the left heel was changed on 8/22/24 for wound care daily. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on nine (9) out of 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's left heel as completed for ten (10) out of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, 25, and 26. A review of Resident #3's medical record revealed there were no weekly wound reports documented for the wound to the left heel until 8/13/24, in which the area was classified as Diabetic/Ischemic. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. Right Heel: A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 8/12/24, for wound care daily. Further review revealed the physician's treatment order for the right heel was changed on 8/21/24 and 8/26/24. A record review of the E-TAR for August 2024 revealed wound care was not documented for Resident #3's right heel as completed for: August 14, 15, 16, 17, 18, 25, and 26. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A record review of the Admission Record revealed that the facility admitted Resident #3 on 12/22/21 with diagnoses including Unspecified Injury to the Cervical Spine Cord and Paraplegia. Resident #4: Right Heel: A record review of the Order Summary Report revealed Resident #4 had a physician's order, dated 5/21/24, for wound care to the right heel daily. Further review revealed the order changed on 8/22/24. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days: July 7, 13, 21, 27, and 31. A record review of the E-TAR for August 2024 revealed that wound care was not documented as completed on three (3) out of 19 days: August 2, 14, and 25. A review of Resident #4's medical record revealed there were no weekly wound reports documented for the wound to the right heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. Sacral: A record review of the Order Summary Report revealed Resident #4 had a physician's order, dated 5/21/24, for wound care to the sacrum daily. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on eight (eight) days out of thirty-one (31) days, July 7, 13, 14, 21, 26, 27, 30, and 31. A record review of the E-TAR for August 2024 revealed that wound care was not documented as completed on seven (7) out of nineteen (19), August 2, 5, 7, 9, 14, 17, and 25 A review of Resident #4's medical record revealed there were no weekly wound reports documented for the wound to the sacrum heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. Left Heel: A record review of the Order Summary Report revealed Resident #4 had a physician's order, dated 6/14/24, for wound care to the left heel every other day. A record review of the E-TAR for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days, July 7, 13, 21, 27, and 31. A record review of the E-TAR for August 2024 revealed that wound care was not documented as completed on four (3) out of 18 days, August 2, 14, 16, and 25. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #4's medical record revealed there were no weekly wound reports documented for the wound to left heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. A record review of the Admission Record revealed that the facility admitted Resident #4 on 08/07/23 with diagnoses including Type 2 Diabetes Mellitus. On 09/24/24 at 1:00 PM, during an interview, the Physician confirmed that weekly wound reports are required for proper wound assessment and progression tracking. He noted that the facility experienced staff changes, including the resignation of the Director of Nursing (DON) and wound nurse, which impacted the consistency of wound documentation during July 2024. On 10/02/24 at 12:58 PM, during an interview with the Wound Nurse, she confirmed that weekly wound assessments should be documented electronically for communication and care planning. She stated this was essential for staff communication regarding different approaches to wound care and/or changes. During an interview on 10/2/24 at 1:10 PM, the Interim-DON revealed the weekly wound observation tool guide was a very important tool to monitor wounds and wound progress. The facility staff was performing wound care on the residents, but some may have been missed with documentation. She explained the facility used the Wound-Weekly Observation Tool to document measurements and characteristics of resident wounds and that they should be completed weekly. She confirmed that Residents #1, #3, and #4 did not have consistent weekly wound documentation completed for July and August. On 10/02/24 at 2:00 PM, during an interview with the Administrator, she acknowledged the facility's staff turnover issues in July 2024, contributed to inconsistent wound documentation. The Administrator explained that the facility had since hired a full-time wound nurse and that a Nurse Practitioner (NP) visits weekly to assess deteriorating wounds and updates care plans. On 10/4/24 at 10:00 AM, during a post survey interview with Wound Care NP, she confirmed that the facility assigned her a list of residents with wounds to be evaluated weekly, including the wounds that have deteriorated. She explained she normally evaluated five (5) or more residents weekly. She revealed she recommends measuring the wounds in the facility weekly to determine their characteristics and size, whether they have any drainage, and whether they have gotten better or worse.		