STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Springs Health & Rehabilitation Center	1199 Ocean Springs Road Ocean Springs, MS 39564

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 0656 Level of Harm - Minimal harm or potential for 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. 43283 Based on interviews, record reviews, and facility policy review, the facility failed to develop care plan interventions for a resident with a Urinary Tract Infection (UTI) (Resident #55) and for a resident with Substance Use Disorder (SUD) (Resident #57), and failed to implement a care plan intervention related to a low air loss mattress (Resident #261) for three (3) of 22 resident care plans reviewed. Findings include: A record review of the facility's policy Plans of Care with revision date 09/25/17 revealed . An individual 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 requirements . Resident #55 On 4/15/24 at 10:55 AM, during an interview, Resident #55 explained he had a UTI and was taking medication for the UTI. Record review of the Admission Record revealed the facility admitted Resident #55 on 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder Record review of the Order Summary Report with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine). Record review of Resident #55's Comprehensive Care Plan revealed there was no care plan with interventions developed related to the diagnosis of UTI. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 03:00 PM on 4/17/24, during an interview and review of the comprehensive care plan, the Director of Nursing (DON) confirmed Resident #55 did not have a care plan in place for UTI and that care plans should be updated when new physician orders are received. The care plan should remain in place until the issue is resolved. She stated she expected care plans to be developed to ensure residents are receiving proper care. On 04/17/24 at 3:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated she was responsible for resident care plans. She confirmed there was no care plan developed for Resident #55 related to his UTI and she confirmed he was currently taking antibiotic medication related to UTI. She explained the purpose of the care plan was for staff to know how to take care of the residents and she expected the staff to follow all resident care plans. Resident #57 On 4/16/24 at 9:00 AM, an interview with Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD. During an interview on 4/16/24 at 10:00 AM, with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD. A record review of the Admission Record revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord. A record review of the Annual MDS with an ARD of 3/20/24 revealed Resident #57 had a BIMS score of 15, which indicated he was cognitively Intact. A review of the medical record for Resident #57 revealed there was no comprehensive care plan developed with interventions related to Substance Use Disorder (SUD). Resident #261 Record review of the comprehensive care plan for Resident #261 with an initiation date of 12/08/23, revealed a Focus (Proper Name) has self-care deficits r/t (related to) needs assistance .Intervention/Tasks . THERAPEUTIC MATTRASS (mattress) . On 4/16/24 at 1:00 PM, in an interview with a family member of Resident #261, she explained she attended a care plan meeting with the facility and the Medical Doctor (MD) apologized to her during the meeting because the Resident #261 was moved from the skilled unit to the long term care (LTC) unit in January of 2024 and the facility did not move his air mattress to the new bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 10:00 AM, in an interview with the Director of Nursing (DON), she confirmed that when Resident #261 moved from the skilled unit to the LTC unit, the low air loss mattress that was ordered for him was not moved to his new bed. Record review of the Admission Record revealed the facility admitted Resident #261 on 9/26/23 with current diagnosis including Injury of Cervical Spinal Cord. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/2024 revealed Resident #261 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37415 Based on interviews, record review, and facility policy review, the facility failed to ensure a Pressure Ulcer (PU) intervention related to an air mattress was continued after a room change for one (1) of three (3) residents reviewed for PUs. Resident #261 Findings include: Review of the facility's policy, Skin and Wound revised 1/24/22, revealed, .To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries .Process .Pressure Injury Mitigation Strategies .Develop resident centered interventions based on resident risk factors . Record review of the Braden Scale dated 10/17/23, revealed Resident #261 had a score of 17, which indicated he was at risk for PUs. Record review of the Order Summary Report revealed Resident #261 had a Physician's Order, dated 10/26/2023 for a low air loss mattress. During an interview on 4/16/24 at 1:00 PM, with a family member of Resident #261, she explained she attended a care plan meeting with the facility and the Medical Doctor (MD) apologized to her during the meeting because the Resident #261 was moved from the skilled unit to the long term care (LTC) unit in January of 2024 and the facility did not move his air mattress to the new bed. Resident #261 was sent to the hospital emergency room due to abnormal laboratory findings and she had the resident admitted to another facility after the hospital stay. During an interview on 4/17/24 at 9:00 AM with the MD, he confirmed that he had apologized to Resident #261's family member during a care plan meeting because the facility did not ensure the low air loss mattress that was ordered for the resident was moved to his new bed when he was moved from the skilled unit to the LTC unit. During an interview on 4/17/24 at 10:00 AM with the Director of Nursing (DON), she confirmed that when Resident #261 moved from the skilled unit to the LTC unit, the low air loss mattress that was ordered for him was not moved to his new bed. Record review of the Admission Record revealed the facility admitted Resident #261 on 9/26/23 with current diagnosis including Injury of Cervical Spinal Cord. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/2024 revealed Resident #261 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.