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	06/22/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to revise Resident #1's comprehensive, person-centered care plan to include individualized interventions for physician-ordered wound care for one (1) of three (3) residents reviewed for care planning, Resident #1.Findings include:A review of the facility's policy Care Plan Revisions Upon Status Change, revised 11/14/2025, revealed, Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change .A record review of the admission Record revealed the facility admitted Resident #1 on 5/20/26 with diagnoses including Amputation. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating his cognition was intact.A record review of the Discharge Instructions revealed, Resident #1 was discharged from a local hospital on 5/20/26 with Orders to .Change dressing daily and as needed with dry gauze and replace ace wrap. A record review of the Order Summary Report for Active, Completed, and Discontinued orders revealed Resident #1 had a Physician's Order, dated 5/29/26, for Wound.RBKA (right below knee amputation) Clean with wound cleanser, apply Xeroform, cover with ABD, wrap with Kerlix every day shift every Mon (Monday), Thu (Thursday). A record review of the Care Plan Report revealed Resident #1 had a focus of I have a surgical wound to the right lower extremity, with a date initiated of 5/29/26. The care plan included interventions to monitor nutritional status, monitor and report changes in skin status, obtain laboratory and diagnostic work as ordered, and complete weekly wound measurements. Resident #1 also had a focus of I have an amputation of the bilateral lower extremities r/t (related to) Diabetes, infection, with a date initiated of 5/29/26. The care plan included interventions related to rehabilitation, pain management, monitoring for bleeding and drainage, monitoring nutritional status to promote wound healing, and monitoring the resident's psychosocial adjustment following the amputation. There were no individualized interventions reflecting the physician-ordered wound treatment initiated on 5/29/26, including cleansing the wound with wound cleanser, applying Xeroform, covering the wound with an ABD, wrapping the wound with Kerlix, or performing dressing changes in accordance with the physician's orders.During an interview with Licensed Practical Nurse (LPN)/MDS #2 on 6/22/26 at 1:14 PM, she revealed there were no care plan interventions or approaches addressing Resident #1's wound care needs. She stated the facility develops an individualized, person-centered care plan for each resident based on the resident's assessed needs and physician orders. LPN #2 confirmed Resident #1's wound care should have been incorporated into the comprehensive care plan and acknowledged this was not completed.During an interview with the Director of Nursing (DON) on 6/22/26 at 3:00 PM, she confirmed Resident #1 was admitted to the facility on [DATE] with physician-ordered wound care following a right below-the-knee amputation. The DON stated the facility's interdisciplinary team is responsible for developing and updating each resident's comprehensive, person-centered care plan to (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflect the resident's current conditions, physician orders, and treatment needs. She acknowledged Resident #1's wound care interventions were not incorporated into the comprehensive care plan after the wound care orders were written on 5/29/26. The DON confirmed the residents' wound care needs should have been included in the care plan to provide staff with individualized guidance for monitoring and managing the resident's wound in accordance with facility policy and professional standards of practice.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to provide treatment and services in accordance with professional standards of practice by failing to timely transcribe physician-ordered wound care into the resident's medical record and failing to document physician-ordered wound treatments in the clinical record for one (1) of three (3) residents reviewed for wound care (Resident #1).Findings include:A review of the facility's policy Documentation of Wound Treatments revised 11/7/2025 revealed, Policy: The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment.Policy Explanation and Compliance Guidelines.3. Wound treatments are documented at the time of each treatment. A review of the facility's policy Provision of Quality of Care, undated, revealed Policy: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices.Policy Explanation and Compliance Guidelines.6. Policies and procedures will reflect current professional standards of practice. A. All employees are responsible for following established policies and procedures. A record review of the Discharge Instructions revealed, Resident #1 was discharged from a local hospital on 5/20/26 with Orders to .Change dressing daily and as needed with dry gauze and replace ace wrap. A record review of the Order Summary Report for Active, Completed, and Discontinued orders revealed Resident #1 had a Physician's Order, dated 5/29/26, for Wound.RBKA (right below knee amputation) Clean with wound cleanser, apply Xeroform, cover with ABD, wrap with Kerlix every day shift every Mon (Monday), Thu (Thursday). This was the first order on the medical record, which was nine (9) days after the facility admitted him.A record review of Resident #1's clinical record, including the Treatment Administration Record (TAR), revealed no documentation that physician-ordered wound treatments were performed from the resident's admission on [DATE] through 5/31/26.On 6/22/26 at 11:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she revealed Resident #1 was admitted to the facility on [DATE] with physician-ordered wound care. LPN #1 acknowledged she provided daily wound care but did not transcribe the physician's wound care orders until 5/29/26, nor did she document the wound care on the TAR or clinical record. She stated physician orders should be transcribed promptly, and wound care should be documented at the time the treatment is provided to ensure continuity of care and an accurate medical record. She acknowledged she did not follow facility policy regarding documentation of wound treatment and dressing changes.On 6/22/26 at 3:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident #1's physician-ordered incision/wound care orders were received from the hospital upon the resident's admission on [DATE]. The DON explained the facility's admission process requires the admission Nurse to enter all physician orders, including wound care orders, into the facility's computerized medical record upon admission. The DON acknowledged that, in this instance, the admission Nurse did not enter the hospital's wound care orders into the electronic medical record. Instead, the admission Nurse provided the paper copy of the hospital wound care orders to a newly hired Registered Nurse (RN), believing the RN would enter the orders into the computerized charting. The DON stated the newly hired RN was unfamiliar with the facility's admission process and did not know she was responsible for entering the physician's orders into the electronic medical record. The DON further stated the facility's wound nurse (LPN #1) was away from the facility for several days following the resident's admission. Upon her return, she received a verbal report regarding Resident #1's wound care and believed the physician's wound care orders had already been entered into the electronic medical record. Approximately nine days after the resident's admission, the wound nurse discovered the wound care orders had not been transcribed into the computerized chart and immediately entered the physician-ordered wound care into the electronic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record on 5/29/26. The DON confirmed this was a breakdown in the facility's admission process and acknowledged the physician's wound care orders were not transcribed in accordance with facility policy. The DON stated facility staff performed Resident #1's wound care in accordance with the hospital discharge instructions despite the delay in entering the physician's orders into the electronic medical record. The DON acknowledged the wound treatments were not documented on the TAR or in the clinical record until 6/1/26, which was not consistent with facility policy. A record review of the admission Record revealed the facility admitted Resident #1 on 5/20/26 with diagnoses including Amputation. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating his cognition was intact.