STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunplex Sub-Acute Center	6520 Sunscope Drive 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415 Based on interviews, record review, and facility policy review, the facility failed to protect a vulnerable resident when Certified Nursing Aide (CNA) #1 and CNA #2 did not safely position Resident #1 in the bed allowing the resident to fall to the floor for one (1) of four (4) residents reviewed for falls. (Resident #1) Findings Include: A review of the facility's undated policy titled Accidents and Incidents revealed: It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and that residents receive supervision and assistive devices to prevent accidents whenever possible . A record review of the facility's investigation revealed on 9/19/24, around 8:05 AM, the Director of Nursing (DON) notified the Administrator of an allegation of abuse between Resident #1 and CNA #1. Resident #1 alleged that CNA #1 pushed her out of bed during care. An investigation was initiated by the DON and the Administrator. CNA #1 was suspended pending investigation, and the incident was reported to the State Agency (SA) Attorney General's Office (AGO), and the local Police Department. The family and the medical director were also notified. The investigation concluded that the allegation of abuse was not substantiated, and the incident was ruled accidental. During an interview on 10/01/24 at 9:15 AM, Resident #1 stated that she was sleepy on 9/19/24 while CNA #1 and CNA #2 provided care and she was unaware that CNA #2 had left the room. She explained that CNA #1 was standing behind her and that CNA #1 pulled the draw sheet to turn her over and it felt like CNA #1 had pushed her out of bed and she fell face down onto the floor. Resident #1 explained that she was unable to grab the bed rails because she did not realize she was that close to the edge of the bed. During an interview on 10/01/24 at 9:30 AM, CNA #1 stated that she was providing care with the help of CNA #2 for Resident #1 on 9/19/24. They were going to transfer her to her wheelchair, but noticed her brief needed to be changed. CNA #2 left the room and CNA #1 stayed in the room with the resident. Resident #1 was positioned on her side and after CNA #2 left the room, the resident began to slide out of bed. CNA #1 stated she was unable to catch the resident, and she fell to the floor. CNA #1 said she went to the door to tell the nurse. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/24 at 10:00 AM, CNA #2 stated that on 9/19/24, CNA #1 had asked for her help with getting the resident up and that she needed a new brief. CNA #2 said she left the room and confirmed the resident was lying on her left side facing the wall. During an interview on 10/03/24 at 9:30 AM, Licensed Practical Nurse (LPN) #2 confirmed that on 9/19/24, she heard a loud thump and saw the resident on the floor after CNA #1 came out of the room. She notified the resident's nurse and prepared the resident for transfer to the emergency room . During an interview on 10/3/24 at 9:46 AM, with LPN #3 she confirmed she was the nurse that was responsible for taking care of Resident #1 on 9/19/24. LPN #3 explained that LPN #2 called for her to come out of the medication room and go to Resident #1's room because she had fallen. LPN #3 stated that when she entered the room CNA#1, was standing in the room in a daze. She asked CNA #1 where the resident was because there was no one in the bed and CNA #1 stated that the resident was on the floor. The nurse stated she observed Resident #1 on the other side of the bed lying on her right side between the bed and the wall. Resident #1 was lying face down on her right side. The nurse stated that the bed was elevated to the waist level and Resident #1 had an opened brief between her legs on the floor that was saturated in urine. LPN #3 said the resident's bed had a draw sheet and an incontinent pad that was saturated in urine. LPN#3 also explained she assessed Resident #1 because she was bleeding from her right elbow, had a bruise on her right side, a bruise on the right side of her head, and her right knee had begun to swell. Resident #1 told her that CNA #1 pushed her out of the bed, and she did not want her back in her room ever again. Resident #1 was then sent to the emergency room for an evaluation. During an interview on 10/03/24 at 11:30 AM, the DON confirmed that she was aware of the fall that occurred with Resident #1 on 9/19/24. The DON stated she immediately began an investigation and made notifications. The DON confirmed the CNA did not ensure Resident #1 was positioned safely in the bed and should have had two people with bed mobility. During an interview on 10/03/24 at 11:45 AM, the Administrator confirmed he had been notified of the fall that occurred on 9/19/24 with Resident #1. He stated the facility investigated the allegation and ruled the fall as accidental. A record review of the Admission Record revealed the facility admitted Resident #1 was admitted to the facility on [DATE] with diagnoses including Paraplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact. Section GG revealed Resident #1 required substantial assistance with rolling left to right while in bed.