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	01/27/2025

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41306 Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident's safety during a bed bath, in which Resident #2 fell from the bed to the floor, sustaining fractures to her bilateral lower extremities for one (1) of four (4) residents reviewed for falls. Findings Include: A review of the facility's policy titled Accidents and Incidents, undated, revealed It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible . A record review of the facility's investigation of Resident #2's fall with fractures revealed that on 12/21/24 at approximately 10:45 AM, Certified Nurse Assistant (CNA)# 1 provided care and a bath to Resident #2 while turning her in the bed on her left side. CNA#1 attempted to reach to hold onto the resident, but due to her being slippery, she rolled out of bed. A record review of the Hospitalist Discharge Note, dated 12/22/24, indicated in the Hospital Course that Resident #2 was receiving a bath when she fell from the bed onto her knees, suffering bilateral femoral fractures . During a phone interview with CNA #1 on 1/22/25 at 3:30 PM, she confirmed that she was assisting Resident #2 with her bed bath. CNA #1 stated that Resident #2 helped during her bath because she could roll in the bed on each side, using the side rail. On that day, since she was slippery due to her bath, she could not catch her while turning. She accidentally fell to the floor on her knees while holding on to the siderail and I could not catch her before she slipped off the bed. CNA #1 immediately notified the nursing supervisor and called for assistance for Resident #2. During a phone interview with Registered Nurse #1 on 1/27/25 at 10:00 AM, she revealed on 12/21/24 that CNA #1 summoned her to Resident #2, finding the resident on the floor next to her bed. CNA #1 stated that when she gave her a bed bath, the resident was slippery and fell to the floor, and she could not catch her from falling. Resident #2 complained of bilateral knee pain and the nurse immediately phoned the local emergency medical response. Then she notified the medical provider, Resident Representative (RR), Director of Nursing (DON), and the Administrator. (continued on next page)

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

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	01/27/2025

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/27/25 at 10:30 AM, during an interview with the DON, she confirmed that she was aware of the fall that occurred with Resident #2 on 12/21/24. The DON stated she immediately began an investigation, and all notifications were made. The DON confirmed that Resident #2 was able to assist with bed mobility for turning and repositioning in her bed for bed baths. The DON stated the fall was an accident due to Resident #2 being wet and slippery during the bed bath. On 1/27/25 at 10:45 AM, an interview with the Administrator confirmed that she was notified of the fall that occurred on 12/21/24 with Resident #2. She stated the facility investigated the allegation and ruled the fall as accidental. A record review of the Admission Record revealed the facility admitted Resident #2 on 3/27/24 and she had diagnoses including Atrial Fibrillation. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/25/2024 revealed Resident #2 had no impairment to her upper extremities, was not dependent for showering and bathing self, and was able to roll left and right with partial/moderate assistance.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41306 Based on staff interview, record review, and facility policy review, the facility failed to ensure its Quality Assurance Performance Improvement (QAPI) program effectively addressed and prevented the recurrence of resident accidents. This failure resulted in a resident sustaining bilateral fractures, despite a prior citation for F689 on 10/3/24, which indicates the facility did not sustain systemic corrective actions to prevent the recurrence for one (1) of four (4) sampled residents. Resident #2. Findings Include: A review of the facility's Quality Assurance and Performance Improvement (QAPI) Program dated 10/22, revealed, .The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents . A record review of the Centers for Medicare and Medicaid Services (CMS) Form 2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), dated 10/3/24, revealed the facility was cited F689 (Accident Hazards) when two Certified Nurse Aides (CNAs) improperly positioned a resident in bed, resulting in a fall with an injury. A record review of the facility's investigation of Resident #2's fall with fractures revealed that on 12/21/24 at approximately 10:45 AM, Certified Nurse Assistant (CNA)# 1 provided care and a bath to Resident #2 while turning her in the bed on her left side. CNA#1 attempted to reach to hold onto the resident, but due to her being slippery, she rolled out of bed. During an interview with the Director of Nurses (DON) on 1/27/25 at 11:00 AM, she confirmed she reviewed the CMS-2567 from the survey on 10/3/24. She stated the facility continued to conduct audits to monitor compliance of residents having a safe environment and to prevent accidents as per the plan of correction. During an interview with the Administrator on 1/27/25 at 11:20 AM, the facility performed audits to monitor the residents for safety and accident prevention. She commented that she was going to take the concerns regarding accident/hazards back to the (QAPI) committee to again develop action plans and audits.