

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Pass Christian Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 538 Menge Avenue Pass Christian, MS 39571	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41306</p> <p>Based on interviews, record review, and facility policy review, the facility failed to administer intravenous (IV) antibiotics for Resident #1 as ordered for two (2) of three (3) scheduled doses.</p> <p>Findings Include:</p> <p>Review of the facility's policy, Physician Orders, revised 3/3/2021, revealed, .The center will ensure that Physician orders are appropriately and timely documented in the medical record .</p> <p>Review of the facility's policy, Administering Medications, revised April 2019, revealed, Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified .21. If a drug is .given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose .</p> <p>Record review of the Admission Record revealed the facility admitted Resident #1 on 3/28/25 with diagnoses including Sialoadenitis and Bacteremia.</p> <p>Record review of the Order Summary Report revealed Resident #1 had a Physician's Order, dated 3/28/25, for ceFAZolin Sodium Intravenous Solution Reconstituted 2 GM (Grams) .Use 2 gram intravenously every 8 (eight) hours for parotitis; sepsis .</p> <p>Record review of the Electronic Medication Administration Record (EMAR) revealed Resident #1 received one (1) dose of Cefazolin Sodium 2 grams IV on 3/29/25 at 0600 (6:00 AM), and the scheduled doses for 3/28/25 at 2200 (10:00 PM) and 3/29/25 at 1400 (2:00 PM) were not documented as administered.</p> <p>Record review of the Omnicell medication dispensing record revealed Cefazolin (1 gram x 2 vials) was removed from emergency stock on 3/29/25 at 10:12 AM by the Director of Nursing (DON). The facility's Omnicell showed pre-stocked Cefazolin 1 gram vials available in emergency stock.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Progress Notes revealed a General Progress Note, dated 3/28/25 at 19:35 (7:35 PM) for Resident #1, which documented Resident arrived to facility at approx (approximately) 1830 (7:30 PM). A General Progress Note, dated 3/29/25 at 21:29 (9:29 PM) for Resident #1 revealed, .IV ATB (Antibiotics) unable to be administered at 2 gm IM (Intramuscular), this writer informed resident and her daughter, per daughter resident needs sent to ER (emergency room) to receive ATB .</p> <p>On 4/29/25 at 10:30 AM, during a phone interview with Resident #1's Resident Representative (RR), she stated Resident #1 did not receive any of the prescribed antibiotics until mid-morning on 3/29/25, and that no further doses were administered. The family requested the resident be transferred back to the local hospital on 3/29/25 later that night so that she could receive her IV antibiotics at the correct times.</p> <p>On 4/29/25 at 2:16 PM, during an interview, the former DON confirmed that although she intended to administer the 10:00 PM dose on 3/28/25, due to personal circumstances, she did not administer that dose and did not inform the Administrator. She acknowledged giving the 3/29/25 6:00 AM dose late, at approximately 10:12 AM but documented the dose on the MAR incorrectly as administered at 6:00 AM. She further stated that the 2:00 PM dose on 3/29/25 was not administered.</p> <p>On 4/30/25 at 9:00 PM, during an interview, the Nurse Practitioner (NP) confirmed that IV antibiotics ordered every 8 hours must be administered as prescribed. She stated that missed or delayed doses could contribute to delayed recovery and increased patient suffering.</p> <p>On 4/30/25 at 2:16 PM, during an interview, the Interim DON confirmed that although she was not present at the time of the incident, the facility's policies require timely medication administration by licensed staff. She confirmed the EMAR and Omnicell record showed only one (1) dose given before the resident's transfer to the ER and acknowledged that the 6:00 AM dose was signed as given but not administered until 10:12 AM, constituting a late and improperly documented dose. She stated this failure violated the facility's expectations and placed the resident at risk for delayed treatment and prolonged infection. The Interim DON also confirmed that the resident's family requested the resident be transferred to the hospital due to the facility's inability to administer the IV antibiotics on schedule.</p>		