STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pass Christian Health and Rehabiliation Center	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)
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. 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 falls 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 4/8/26 with diagnoses including Acquired Absence of Right and Left Leg Below the Knee. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/13/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 08, indicating her cognition was moderately impaired. A record review of the Progress Note revealed, on 5/4/26 at 11:40 PM, Resident #1 slid off of bed trying to transfer self. A record review of the Progress Note revealed, on 5/9/26 at 11:48 PM, Resident #1 was noted sitting on the floor next to the bed. A record review of Resident #1's Care Plan Report revealed a care plan focus, initiated on 06/18/2026, stating, The resident has had an actual fall with no injury, r/t (related to) poor balance, BBKA (bilateral below-knee amputee). Has repeated falls. Interventions associated with this focus included monitoring floor mats on the floor to side of bed every shift for decreased safety. A separate care plan focus, The resident is at risk for falls r/t (related to) weakness, BBKA, and paraplegia, was also revised on 06/18/2026 and included interventions to ensure the resident's call light was within reach, encourage the resident to use the call light for assistance as needed, and provide a prompt response to the resident's requests for assistance. The comprehensive care plan was not revised following Resident #1's falls on 05/04/2026 and 05/09/2026 to reflect the resident's change in condition or the individualized interventions implemented following those events.On 06/30/2026 at 10:46 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed Resident #1 had a baseline care plan addressing fall risk. She confirmed Resident #1 experienced three (3) falls while residing at the facility on 05/04/2026, 05/09/2026, and 06/18/2026. LPN #1 stated that residents who experience falls are discussed during the facility's morning clinical meetings and that nursing staff are responsible for completing incident reports and communicating information necessary for care plan revisions. She acknowledged she was aware of Resident #1's falls on 05/04/2026 and 05/09/2026; however, the resident's comprehensive care plan was not revised to reflect the falls or the individualized interventions implemented following each event. She confirmed the comprehensive care plan was not updated as required and acknowledged that care plans should be individualized, reflect the resident's current needs, and be revised following significant changes in condition, including falls.During an interview on 6/30/26 at 11:45 AM, with LPN #2 confirmed, Resident #1 experienced two unwitnessed falls on 5/4/26 and 5/9/26. She confirmed nursing staff implemented interventions following each fall, including obtaining physician orders for a fall mat and maintaining the bed in the lowest position. She documented the above in the progress notes. She confirmed these (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were not incorporated into the resident's comprehensive care plan.On 06/30/2026 at 12:15 PM, during an interview with the Director of Nursing (DON), she stated she was recently hired and new to her position. After reviewing Resident #1's clinical record, she confirmed the resident experienced unwitnessed falls on 05/04/2026 and 05/09/2026. She confirmed the facility completed both an admission baseline care plan and a comprehensive care plan; however, the comprehensive care plan was not revised following either fall. The DON confirmed nursing staff completed post-fall assessments, notified the physician, and implemented interventions including placing a floor mat at the bedside, maintaining the bed in the lowest position, and instructing the resident to use the call light for assistance. She acknowledged these individualized interventions should have been incorporated into the resident's comprehensive, person-centered care plan to accurately reflect the resident's current needs and provide staff with current guidance to reduce the resident's risk for subsequent falls. The DON agreed that the failure to revise the comprehensive care plan following the falls on 05/04/2026 and 05/09/2026 was not consistent with the facility's policy or accepted standards of nursing practice.On 06/30/2026 at 12:30 PM, during an interview with the Administrator, he confirmed Resident #1 experienced multiple falls while residing at the facility. He confirmed nursing staff implemented interventions following each fall; however, the resident's comprehensive care plan was not revised following the falls on 05/04/2026 and 05/09/2026 to reflect the individualized interventions implemented in response to the resident's change in condition. The Administrator acknowledged the comprehensive, person-centered care plan should be reviewed and revised following significant changes in a resident's condition to accurately reflect the resident's current needs and provide staff with current guidance regarding the resident's care and interventions.