STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Nursing Center	1500 Broad Avenue Gulfport, MS 39501

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. 43283 Based on staff interviews, record review, and the facility policy review, the facility failed to develop appropriate interventions for a cognitively impaired resident after a fall to prevent reoccurrence for one (1) of three (3) sampled residents. Resident #1 Findings include: A record review of the facility's policy Fall Risk Assessment with revised date 01/05/24 revealed . It is the policy of this facility to provide an environment that is free from accidents and hazards .Policy Explanation and Compliance Guidelines: . 4. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident . A record review of the Witnessed Fall Report dated 05/15/24 revealed Resident #1 had a fall in the hallway. When the staff asked Resident #1 what had happened, he indicated that he did not know. A record review of the Witnessed Fall Report dated 05/23/24 revealed Resident #1 had a fall in his room. The resident's roommate stated that the resident was trying to get in the bed. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/24 revealed Resident #1's cognitive skills for daily decision making were moderately impaired. Record review of the care plan with an initiation date of 10/31/23 revealed Problem Falls: At risk for falls r/t (related to) .cognitive impairment Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .date initiated 5/20/2024 .Educate resident/family/caregivers about safety reminders and what to do if a fall occurs. Date initiated 5/24/24 . The care plan indicated Resident #1 had a witnessed fall out to the wheelchair on 5/15/24 and another witnessed fall on 5/23/24 transferring from the wheelchair to bed unassisted. (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
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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 - Minimal harm or potential for actual harm Residents Affected - Few	At 12:10 PM on 06/27/24, during an interview with the Director of Nursing (DON), she confirmed Resident #1 was severely cognitively impaired and had memory loss. She explained he did not say many words but would answer yes and no questions. She stated she did not think Resident #1 could remember to use the call light or remember safety education provided to him. The DON reviewed Resident #1's care plan and confirmed after the resident's fall on 05/15/24 the intervention that was developed was to keep the call light within reach and encourage the resident to use it. The DON confirmed that was not appropriate for Resident #1 because of his cognitive impairment. She also confirmed the intervention initiated on 05/24/23 after the resident's second fall that was developed was to educate the resident about safety reminders and confirmed that was also not appropriate. She stated she expected care plan interventions to reflect the resident's individual needs and the care plan nurse to develop interventions that are appropriate for residents. On 06/27/24 at 12:35 PM, during an interview with Registered Nurse (RN) #1, she stated she was responsible for developing care plan interventions after a resident had a fall. She confirmed care plan interventions for Resident #1 included safety education and to encourage the resident to use the call light. She confirmed Resident #1 had memory problems and was oriented only to person. Resident #1 could not remember things and if his call light was in reach, he was cognitively impaired and would not know or remember how to use it. On 06/27/24 at 4:30 PM, during an interview with the Administrator, she explained the facility discussed falls and interventions daily and she expected the care plan nurse to add appropriate interventions to resident care plans to prevent future falls. A record review of the Admission Record revealed the facility admitted Resident #1 on 07/19/2022 with diagnoses that included Hemiplegia and Hemiparesis.