STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255341	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfport Care Center	11240 Canal Road Gulfport, MS 39503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306 Based on interviews, record review, facility investigation, and policy review, the facility failed to treat a resident with respect and dignity during care for one (1) of four (4) residents sampled. Resident #2 Findings included: A review of the facility's policy titled, Resident Rights Policy, reviewed 12/23, revealed, Every resident in this facility has the right to: .12. Be treated courteously, fairly and with the fullest measure of dignity . A review of the facility's investigation revealed there was an allegation of verbal abuse reported to the facility on [DATE], by Resident #5, the roommate of Resident #2. Resident #5 reported that a Certified Nurse Aide (CNA) had verbally abused her roommate while providing care. Resident #5 reported that a CNA told Resident #2 that she needed to get her 'expletive' up and go the bathroom, when the resident had an accident in the bed. On 4/30/24 at 10:45 AM, during an interview with the Social Services Director (SSD), she confirmed that on 3/22/24, Resident #5, the roommate of Resident #2, informed her that during the early hours of 3/22/24, a CNA told Resident #2 to get her 'expletive' up and get into the bathroom. The SSD revealed that once she received this information, she immediately informed the Administrator and they began their investigation. On 4/30/24 at 11:00 AM, during an interview with Resident #2, she confirmed that about a month ago, during the early morning hours, she urinated on herself and called out for help. The nurse checked on her, then the CNAs entered her room, and one CNA told her something not nice and spoke ugly. On 4/30/24 at 1:00 PM, during an interview with the Director of Nurses (DON), she confirmed Resident #5 is alert/oriented and if she reported that a staff member was disrespectful to another resident, then she would have to say it did happen. Resident #5 was clear on what she heard on 3/22/24, and her statement had not changed. The DON confirmed staff should not talk to residents in a disrespectful way. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 11:10 AM, during an interview with the Administrator, she confirmed that during her investigation, both Resident #2 and Resident #5 reported that a staff member used inappropriate language when addressing Resident #2. The Administrator acknowledged that her investigation revealed the CNA that the residents described, was CNA #1. The Administrator acknowledged that the language used by CNA #1 was disrespectful but was not threatening. As this was the second time that CNA #1 had been accused of being discourteous to residents, she was terminated from her employment at the facility. The Administrator stated that after the recent incident, the facility had an emergency Quality Assurance Performance Improvement (QAPI) meeting to discuss the event and what measures needed to be implemented. As a result, in-services were conducted regarding resident rights and abuse/neglect. On 5/1/24 at 1:00 PM, an interview with Resident #5 confirmed that about a month ago, in the early morning hours, her roommate, Resident #2, used the bathroom on herself, it was a big mess, and it went onto the floor. Two (2) CNAs came in to clean her up but one of the CNAs, who had a head wrap on, stated, get your 'expletive' up and get into the bathroom. Resident #5 stated they took her roommate to the shower to clean her up and brought her back to her room. Resident #5 confirmed that she informed the Social Worker the next day of what took place earlier that morning. A review of the personnel file for CNA #1 indicated she had received training on the Vulnerable Adults Act and Resident's Rights and signed an acknowledgment of receiving training on 4/21/22, upon hire, then annually and throughout the year. Record review of the Facesheet, for Resident #2, revealed the facility admitted the resident on 12/9/22, with current diagnoses of Altered Mental Status and Chronic Kidney Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/4/24, revealed Brief Interview for Mental Status (BIMS) score is 15, which indicated the resident was cognitively intact. Record review of the Quarterly MDS, for Resident #5, with an ARD of 2/22/24, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Based on the facility's implementation of corrective actions on 3/25/24, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC), and the deficiency was corrected as of 3/25/24, before the SA's entrance on 4/30/24. Validation: On 5/2/24, the SA validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when the incident occurred. A review of the emergency QAPI meeting minutes revealed the facility held a QAPI meeting on 3/25/24, the Medical Director attended via phone. The SA verified through an interview with the DON and Social Services Director that they attended the QAPI meeting to discuss the situation, and the facility policies related to violation of the resident rights were discussed, and no changes were needed. The QAPI meeting concluded that the Plan of Correction was to in-service all staff, suspend the employee, and interview all residents with a Brief Interview for Mental Status (BIMS) score over 12, to determine if any resident experienced any violation of their resident rights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SA reviewed in-service sign-in sheets that began on 3/22/24 related to resident rights and abuse/neglect. The Administrator and DON conducted in-services in which they had every employee sign the policies on resident rights and abuse/neglect. On 3/22/24, the SA verified the facility reported resident abuse to the SA and the Attorney General Office (AGO) on 3/22/24.