

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Singing River Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 2809 Denny Avenue Pascagoula, MS 39581	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43283</p> <p>Based on interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent a fall for one (1) of five (5) sampled residents. Resident #1</p> <p>Findings include:</p> <p>A record review of the facility's policy Patient Rights and Responsibilities Policy, effective date 02/2024, revealed . This policy aims to create a framework to protect and promote patients' rights within (Proper Name), guiding employees to deliver care with respect to individuals rights .Patient Rights: you have a right to: 1. Considerate care . 13. Receive care in a safe setting .</p> <p>A record review of the facility's policy Fall Risk Assessment, Prevention, and Management, effective date 09/2022 revealed . (Proper Name) engages in safe practices that support prevention of patient falls and prevention of injury with falls . utilizes risk assessment tools to risk stratify patient risk for fall, subsequently outlining recommendations for actions to consider based on the identified risk . The purpose of this policy is to promote safety .</p> <p>A record review of the Risk Management Worksheet for Resident #1 with event date and time 02/02/25 at 07:40 PM and was entered by Licensed Practical Nurse (LPN) #1 revealed . comments . 02/03/25 08:33 PM . heard a noise when in room with another patient when I heard a sound, when looking in rooms patient noted on floor in bathroom . LPN #1 reported that patient was on commode but was left unattended by Certified Nurse Aide (CNA) #1. CNA #1 put patient on commode, left room to give handoff and then left for the day . He was cooperative and impulsive, but confused and forgetful. After observing the patient transfer, it was obvious patient could not transfer independently . x-ray hip left . 02/03/25 08:16 PM . impression: no evidence of acute abnormality .</p> <p>A record review of Resident #1's Post Fall Analysis dated 02/03/25 at 07:40 PM revealed the known patient related risk included lower extremities weakness, impaired gait, and requires assistive devices. Handwritten notation included that CNA#1 put patient on bedside commode, left patient to give handoff and left for day .</p> <p>A record review of Resident #1's Patient Information form revealed the facility admitted the resident on 01/16/25 and he was discharged home on 02/04/25 with the Admission Complaint listed as Left Hip Fracture.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Summary Score of 1, which indicated his cognition was severely impaired.</p> <p>On 02/20/2025 at 9:00 AM, during a phone interview, the complainant stated a staff member from the facility called him and informed him his father had fallen off the commode while no one was present in the room. According to the complainant, the nurse explained that staff had just left the room, and within seconds, his father fell. The complainant stated that his father had recently undergone surgery on his left hip. Although no new injuries were sustained from the fall and an x-ray was completed, the complainant expressed concern that the incident could have been serious. He stated that he believes no resident, especially those with dementia and confusion, should be left unsupervised.</p> <p>On 02/20/25 at 09:20 AM, during an interview with the facility's Operational Manager, confirmed Resident #1 was no longer at the facility and the son decided to take resident home the day after the fall occurred.</p> <p>On 02/20/2025 at 9:45 AM, during an interview, CNA #2 explained she remembered Resident #1, who resided on a different unit. She recalled assisting his assigned CNA in helping Resident #1 onto the commode in his bathroom on the night of the fall. She confirmed that Resident #1 was safely assisted to the commode before she left the room. CNA #2 stated that the transfer occurred right at shift change, and the incoming night shift CNA was informed that Resident #1 was on the commode. She explained that she left the room because her shift had ended.</p> <p>On 02/20/2025 at 11:00 AM, during an interview, CNA #5 stated that she remembered Resident #1, who had been at the facility for a few weeks. She described Resident #1 as confused and noted that he frequently tried to get up and walk on his own. She stated that Resident #1 had recently undergone hip surgery, and staff would bring him to the hallway to interact with others, which helped keep him calm. CNA #5 recalled that Resident #1 had only one fall during his stay at the facility, which occurred during shift change. She explained that Resident #1 had been sitting at the nurse's station, and during the last round, CNA #1 took him to his room and placed him on the commode in the bathroom before leaving the room. CNA #5 stated that Resident #1 was left unattended on the commode because it was shift change. She also stated that both she and CNA #1 repeatedly informed the oncoming staff, including CNA #3, that Resident #1 was on the commode.</p> <p>On 02/20/2025 at 12:30 PM, during an interview, the Operational Manager stated that she was aware of Resident #1 and his fall on 02/03/2025. She explained that an x-ray was obtained the same night to assess for any injuries. She noted that Resident #1 had dementia and frequently attempted to get up and walk on his own. She further stated that Resident #1 did not like anyone near him, was confused, could not be redirected, and was unable to follow instructions to call for assistance. The Operational Manager stated that staff should not have left Resident #1 unattended on the commode in the bathroom. She emphasized that she expects staff to provide adequate supervision to all residents to prevent accidents.</p> <p>On 02/20/2025 at 12:45 PM, during an interview, the Administrator stated that no confused resident should be left unattended or unsupervised while on the commode. He emphasized that he expects staff to provide adequate supervision to all residents to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/20/2025 at 3:00 PM, during a phone interview, LPN #2 confirmed that she was the nurse on duty from 7:00 AM to 7:00 PM on the day Resident #1 was left unattended on the commode and subsequently fell . She stated that she was conducting rounds with the incoming night shift nurse, LPN #1, at the time of the incident. LPN #2 explained that the day shift CNAs had placed Resident #1 on the commode right at shift change and left him unattended. She further stated that instead of the night shift CNA staying with Resident #1, the CNA was obtaining vital signs from other residents. LPN #2 confirmed that both the night shift nurse and the night shift CNA were informed at shift change that Resident #1 was on the commode. LPN #2 stated that while she was in another resident's room with the night shift nurse, they both heard a thump and immediately went to check on Resident #1. They found him lying on the floor in the bathroom beside the commode.</p> <p>On 02/20/2025 at 4:00 PM, during a phone interview, CNA #3 stated that she remembered Resident #1 and the night he fell . However, she did not recall any staff member or day shift CNA informing her that Resident #1 was on the commode. She stated that she was unaware that Resident #1 had been left unattended on the commode. CNA #3 explained that she was obtaining vital signs from other residents when she was informed by Licensed Practical Nurse (LPN) #1 that Resident #1 had fallen. She stated that she then went to assist the nurse with Resident #1 and observed him lying on the floor in his bathroom beside the commode. CNA #3 stated that she did not notice any injuries but was aware that Resident #1 had an x-ray completed following the fall.</p> <p>On 02/20/2025 at 4:30 PM, during a phone interview, LPN #1 confirmed that she was the night nurse on duty when Resident #1 fell . She stated that she was in another resident's room when she heard a thump. She then went from room to room to investigate and eventually heard Resident #1 moaning. She found him lying on the bathroom floor beside the commode. LPN #1 stated that she immediately notified the CNA and then contacted Resident #1's son, physician, and the Director of Nursing (DON). She confirmed that Resident #1 was confused and forgetful and stated that she was aware he had been left unattended on the commode. LPN #1 stated that x-rays were completed and confirmed that Resident #1 did not sustain any injuries from the fall.</p> <p>On 02/20/2025 at 4:45 PM, during a phone interview, CNA #1 confirmed that she was the CNA who assisted Resident #1 to the bathroom commode with the help of another CNA. She stated that Resident #1 was confused, had Dementia, and required assistance for transfers. CNA #1 explained that she expected the night shift CNA to go directly to Resident #1 after being notified that he was on the commode. However, she stated that although the nurses and the night CNA were informed, the night CNA did not go to the bathroom to supervise Resident #1. Instead, she went to obtain vital signs from other residents. CNA #1 confirmed that Resident #1 was left unattended on the commode and acknowledged that he should not have been left alone. However, she was unsure of the exact length of time that Resident #1 was left unsupervised.</p>		