

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER SUNPLEX SUB-ACUTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The State Agency (SA) conducted complaint investigations (CIs), MS #26532, CI MS #26567, and CI MS #26438 at the facility from 10/1/24 to 10/3/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS #26438 was investigated related to sexual abuse and there were no citations regarding the complaint. CI MS #26532 and CI MS #26567 was investigated regarding abuse, falls, residents treated with respect and dignity, and quality of life and F689 was cited.	F 000			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to protect a vulnerable resident when Certified Nursing Aide (CNA) #1 and CNA #2 did not safely position Resident #1 in the bed allowing the resident to fall to the floor for one (1) of four (4) residents reviewed for falls. (Resident #1) Findings Include:	F 689	1. Resident # 1 was assessed by nursing team and sent out to the ER to be further evaluated. Resident # 1 had no major injuries from the incident. 2. All residents in the facility have the potential to be affected by this practice.	10/23/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/22/2024

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.

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F 689	Continued From page 1 A review of the facility's undated policy titled "Accidents and Incidents" revealed: "It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and that residents receive supervision and assistive devices to prevent accidents whenever possible ..." A record review of the facility's investigation revealed on 9/19/24, around 8:05 AM, the Director of Nursing (DON) notified the Administrator of an allegation of abuse between Resident #1 and CNA #1. Resident #1 alleged that CNA #1 pushed her out of bed during care. An investigation was initiated by the DON and the Administrator. CNA #1 was suspended pending investigation, and the incident was reported to the State Agency (SA) Attorney General's Office (AGO), and the local Police Department. The family and the medical director were also notified. The investigation concluded that the allegation of abuse was not substantiated, and the incident was ruled accidental. During an interview on 10/01/24 at 9:15 AM, Resident #1 stated that she was sleepy on 9/19/24 while CNA #1 and CNA #2 provided care and she was unaware that CNA #2 had left the room. She explained that CNA #1 was standing behind her and that CNA #1 pulled the draw sheet to turn her over and it felt like CNA #1 had pushed her out of bed and she fell face down onto the floor. Resident #1 explained that she was unable to grab the bed rails because she did not realize she was that close to the edge of the bed. During an interview on 10/01/24 at 9:30 AM, CNA	F 689	3. The Director of Nursing (DON) and Administrative Nurse completed in-services with staff on Falls, Reporting, Incidents, and Reporting to include all accidents on 09/20/24 as well as on Transfers, Care Plans, CNA Care Plans, Assist Levels, and Bed Mobility on 09/19/24. 4. The Transitional Care Unit (TCU) Manager, Administrative Nurse, Assistant Director of Nursing (ADON), Director of Nursing (DON), or Administrator will complete audits to ensure the Resident environment remains as free of accident hazards as possible and Residents receive adequate supervision and assistance to prevent accidents by observations of care and checking for proper resident positioning during care. The TCU Manager, Administrative Nurses, ADON, DON, or Administrator will complete audits to begin on 09/27/24, to include one (1) Resident weekly for 30 days; then one (1) Resident monthly for 3 months to ensure the Resident environment remains as free of accident hazards as possible and Residents receive adequate supervision and assistance to prevent accidents. Any concerns related to hazards in the facility will be addressed immediately. The results of such audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 3 months to end on January 27, 2025.		

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F 689	Continued From page 2 #1 stated that she was providing care with the help of CNA #2 for Resident #1 on 9/19/24. They were going to transfer her to her wheelchair, but noticed her brief needed to be changed. CNA #2 left the room and CNA #1 stayed in the room with the resident. Resident #1 was positioned on her side and after CNA #2 left the room, the resident began to slide out of bed. CNA #1 stated she was unable to catch the resident, and she fell to the floor. CNA #1 said she went to the door to tell the nurse. During an interview on 10/01/24 at 10:00 AM, CNA #2 stated that on 9/19/24, CNA #1 had asked for her help with getting the resident up and that she needed a new brief. CNA #2 said she left the room and confirmed the resident was lying on her left side facing the wall. During an interview on 10/03/24 at 9:30 AM, Licensed Practical Nurse (LPN) #2 confirmed that on 9/19/24, she heard a loud thump and saw the resident on the floor after CNA #1 came out of the room. She notified the resident's nurse and prepared the resident for transfer to the emergency room. During an interview on 10/3/24 at 9:46 AM, with LPN #3 she confirmed she was the nurse that was responsible for taking care of Resident #1 on 9/19/24. LPN #3 explained that LPN #2 called for her to come out of the medication room and go to Resident #1's room because she had fallen. LPN #3 stated that when she entered the room CNA#1, was standing in the room "in a daze." She asked CNA #1 where the resident was because there was no one in the bed and CNA #1 stated that the resident was on the floor. The nurse stated she observed Resident #1 on the	F 689	The first QAPI meeting to review such audits will be held on 10/22/24. If the QA team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education. 5. Completion date as of 10/23/24.		

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F 689	Continued From page 3 other side of the bed lying on her right side between the bed and the wall. Resident #1 was lying face down on her right side. The nurse stated that the bed was elevated to the waist level and Resident #1 had an opened brief between her legs on the floor that was saturated in urine. LPN #3 said the resident's bed had a draw sheet and an incontinent pad that was saturated in urine. LPN#3 also explained she assessed Resident #1 because she was bleeding from her right elbow, had a bruise on her right side, a bruise on the right side of her head, and her right knee had begun to swell. Resident #1 told her that CNA #1 pushed her out of the bed, and she did not want her back in her room ever again. Resident #1 was then sent to the emergency room for an evaluation. During an interview on 10/03/24 at 11:30 AM, the DON confirmed that she was aware of the fall that occurred with Resident #1 on 9/19/24. The DON stated she immediately began an investigation and made notifications. The DON confirmed the CNA did not ensure Resident #1 was positioned safely in the bed and should have had two people with bed mobility. During an interview on 10/03/24 at 11:45 AM, the Administrator confirmed he had been notified of the fall that occurred on 9/19/24 with Resident #1. He stated the facility investigated the allegation and ruled the fall as accidental. A record review of the "Admission Record" revealed the facility admitted Resident #1 was admitted to the facility on 11/6/23 with diagnoses including Paraplegia. A record review of the "Quarterly Minimum Data	F 689			

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F 689	Continued From page 4 Set (MDS)" with an Assessment Reference Date (ARD) of 08/07/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact. Section GG revealed Resident #1 required substantial assistance with rolling left to right while in bed.	F 689			