STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 two (2) Complaint Investigations (CI MS #27078 and CI MS #27005), at the facility from 11/25/24 through 11/26/24. CI MS #27078 was investigated related to neglect, delay in treatment and poor quality of care related to failure to assess a resident for an impaction. CI MS #27005 was investigated related to poor quality of care related to leaving a resident wet for a long period of time and sexual abuse. There were no citations related to CI MS #27005. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid related to CI MS #27078 and cited F600, F684, and F656. The facility held a licence for 180 beds with a census of 127.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		12/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 600	Continued From page 1 by: Based on interviews, record reviews, and facility policy reviews, the facility failed to protect the resident's right to be free from neglect when the facility failed to implement measures to prevent a resident from becoming fecally impacted causing a hospitalization that included dis-impaction and intravenous fluids and neglected to communicate the impaction to the physician for one (1) of four (4) residents reviewed. Resident #1 Findings included: A review of the facility's policy titled "Abuse, Neglect, Exploitation and Misappropriation," revised 11/16/22 revealed "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property... Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ..." A review of the facility's policy titled, "Resident and Patient Rights," revised 09/01/17, revealed, "It is the policy of The Company that all employees will conduct themselves in a professional manner at all times, respecting the rights of each resident or patient to privacy, personal care, self-respect, and confidentiality ... It is the responsibility of all care center employees to notify the Executive Director, Director of Clinical Services, or their immediate supervisor immediately if they observe or become aware of an incident of resident abuse and/or neglect,	F 600	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by the provisions of Federal and State Laws. F600 *Resident #1 transferred to hospital on November 8, 2024. Resident #1 observed for bowel movement on November 17, 2024, by Licensed Practical Nurse #1, no significant findings. Licensed Practical Nurse #1 received education regarding documentation of medication administration, resident change in condition, provider notification, Abuse and Neglect, and Resident Rights, on November 26, 2024, by Director of Nursing. *All Residents have potential to be affected. * All clinical staff received education regarding documentation of medication administration, resident change in condition, provider notification, Abuse and Neglect, and Resident Rights, beginning on November 26, 2024, by Unit Manger. *Monitoring began on November 26, 2024, by Director of Nursing. The Director of Nursing will monitor bowel movement records weekly for three (3) weeks then monthly times (3) months. Findings will be brought to the Quality Assurance Performance Committee Meeting monthly for three months by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 600	Continued From page 2 whether alleged, suspected, or observed ..." A review of Resident #1's "Face Sheet" revealed the resident was admitted to the facility on 02/12/2014 with diagnoses including Constipation, Chronic Pain, Muscle Weakness, and Heart Failure. A review of Resident #1's comprehensive care plan, revised on 07/02/2024, revealed the resident was at risk for constipation related to limited mobility, daily use of narcotic medications, and diuretics. The interventions included administering Colace 100 milligrams (mg) orally daily and Senna-S 8.6-50 mg daily, encouraging and offering fluids every shift, providing a water pitcher at the bedside, and notifying the provider if no bowel movement occurred within three (3) days. A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 09/20/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. A record review of local hospital notes, dated 11/11/2024, revealed Resident #1 was admitted on 11/08/2024 due to hypotension, constipation with generalized weakness, poor appetite, and lower abdominal pain. A Computed Tomography (CT) scan revealed severe constipation with fecal impaction, right hydronephrosis, and acute kidney injury related to severe constipation. The resident underwent dis-impactions, laxatives, intravenous (IV) fluids for dehydration, and potassium protocol for severe hypokalemia. Potassium upon admission was 2.5. The resident was discharged	F 600	Director of Nursing to determine effectiveness and make necessary changes as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 600	Continued From page 3	F 600		

on 11/15/2024.

During an interview on 11/25/2024 at 9:00 AM, Resident #1's son stated he visited his mother on 11/05/2024 and noticed she was weak, fatigued, and not eating. He reported these concerns to the former Administrator and staff but felt no action was taken until 11/08/2024 when the Emergency Management System (EMS) transported his mother to the hospital.

During an interview on 11/25/2024 at 10:00 AM, the Social Worker stated she received a call from Resident #1's son on 11/08/2024 expressing concerns about his mother's health. He requested immediate hospitalization due to her swollen abdomen and lack of bowel movements.

During an interview on 11/26/2024 at 9:00 AM, Licensed Practical Nurse (LPN) #1 confirmed she noted hard stool in Resident #1's rectum on 11/07/2024. She stated she administered MiraLAX and Lactulose and documented the incident in the Nurse Practitioner's (NP) notification book.

A record review of the Nurse's Notes, dated 11/07/2024, revealed no documentation of an impaction or medication administration.

A record review of the "Medication Administration Record (MAR)" and Physician's Orders for November 2024 revealed no documentation for MiraLAX or Lactulose until after the resident returned from the hospital on 11/15/2024.

During an interview on 11/26/2024 at 10:15 AM, the NP stated she did not receive any notification about Resident #1's impaction. She reviewed her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 600	Continued From page 4 notification book and found no entry regarding the issue. During an interview on 11/26/2024 at 11:00 AM, the Director of Nursing (DON) confirmed there was no documentation of a possible impaction prior to 11/08/2024. She stated the resident's son requested hospitalization due to concerns about her condition.	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		12/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 656	Continued From page 5 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to ensure the comprehensive care plan was implemented for one (1) of four (4) residents reviewed. Resident #1 Findings included: A review of the facility's policy titled "Plans of Care," revised 09/25/2017, revealed, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or representative(s) to the extent practicable and updated in accordance with the state and federal regulatory requirements ...Procedure ...implement an Individualized Person -Centered comprehensive plan of care ...as determined by the resident's needs ..."	F 656	F656 *Resident #1 Care Plan was reviewed by Director of Nursing, on November 26, 2024, and no identified issues to Resident #1 Care Plan regarding constipation. On November 26, 2024, Minimum Data Set (MDS) nurse and two (2) Care Plan Licensed Practical Nurses received education by Director of Nursing, on Facility policy Plan of Care. * All residents have the potential to be affected. * All clinical staff received education regarding documentation of medication administration, resident change in condition, provider notification, Abuse and Neglect, and Resident Rights, on November 26, 2024, by Unit Manger. Beginning on November 26, 2024, MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 656	Continued From page 6 Record review of Resident #1's comprehensive care plan, revised on 07/02/2024, revealed "(Proper name of Resident #1) is at risk for constipation R/T (related to) limited mobility (diagnosis) constipation, daily use of narcotic medication, and diuretics ....Interventions/Task ...Observe for signs and symptoms of constipation every shift, such as abdominal bloating, abdominal pain or cramps, hypoactive bowel sounds, and watery stool ...Notify provider as needed." Record review of the care plan with a revision date of 9/24/24 revealed "(Proper name of Resident #1) has a self-care deficit and impaired functional abilities ...R/T ...Chronic pain ...Interventions/Task ...Check frequently (at least every 2 hours) for incontinent episodes ..." During an interview on 11/26/2024 at 9:00 AM, Licensed Practical Nurse (LPN) #1 confirmed she noticed the resident had runny and hard stool in her rectum on 11/07/2024. She stated she administered MiraLAX and Lactulose and documented the issue in the Nurse Practitioner's (NP) notification book. LPN #1 said she knew the resident had a history of constipation and often refused laxatives. She stated she informed the NP to check the notification book but did not call her directly. LPN #1 admitted the care plan required notifying the provider but believed documenting in the notification book was sufficient. A record review of the "Progress Notes" and "Nurse's Notes" for 11/07/2024 revealed no documentation of the runny and hard stool observed by LPN #1 indicating a possible impaction or medication administration.	F 656	nurse conducted a Quality Review of current residents Care Plan to follow the comprehensive care plans to reflect specific residents needs related to constipation. *Monitoring began on November 26, 2024, by Minimum Data Set (MDS) Licensed Practical Nurse. MDS will monitor three (3) care plan records for three (3) weeks then monthly times three (3) months. Finding will be brought to the Quality Assurance Performance Committee Meeting monthly times 3 months by MDS beginning December 20, 2024, to determine effectiveness and make necessary changes as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 656	Continued From page 7	F 656		

A record review of the "Physician's Orders" and "Medication Administration Record (MAR)" for November 2024 revealed no documentation for MiraLAX or Lactulose until 11/15/2024, after the resident returned from the hospital.

During an interview on 11/26/2024 at 10:15 AM, the NP stated she checked her notification book and found no entry regarding a possible impaction. She confirmed she was not informed of Resident #1's condition.

During an interview on 11/26/2024 at 10:30 AM, Registered Nurse (RN) #1 confirmed LPN #1 failed to follow the care plan by not notifying the Medical Director or NP. RN #1 stated the care plan required notifying the provider for signs and symptoms of constipation, including abdominal bloating, pain, or cramps, and hypoactive bowel sounds. RN #1 emphasized that staff were expected to follow the care plan when providing care.

During an interview on 11/26/2024 at 11:00 AM, the Director of Nursing (DON) confirmed there was no documentation indicating the NP or Medical Director was informed of the possible impaction. The DON acknowledged LPN #1 failed to follow the care plan.

A record review of the "Admission Record," for Resident #1 revealed the facility admitted the resident on 02/12/2014. The resident's diagnoses included Constipation, Chronic Pain, Muscle Weakness, and Heart Failure.

A review of Resident #1's Quarterly Minimum Data Set (MDS) with the Assessment Reference

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 656	Continued From page 8 Date (ARD) of 09/20/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to ensure a resident received care and services to prevent an impaction causing a hospitalization and a physical decline and failed to communicate the impaction to the physician for one (1) of four (4) residents reviewed. Resident #1 Findings included: A review of the facility's policy titled, "Bowel and Bladder Evaluation," revised 08/28/2017, revealed "Residents are evaluated for continence upon admission/readmission, quarterly, and with significant changes in status. Residents who are determined to be incontinent without a documented irreversible cause are further evaluated for potential bowel and/or bladder management ..."	F 684	F684 *Resident #1 transferred to hospital on November 8, 2024. Resident #1 observed for bowel movement on November 17, 2024, by Licensed Practical Nurse #1, no significant findings. Licensed Practical Nurse #1 received education regarding documentation of medication administration, resident change in condition, provider notification, Abuse and Neglect, and Resident Rights, on November 26, 2024, by Director of Nursing. *All Residents have potential to be affected. * All clinical staff received education regarding documentation of medication administration, resident change in condition, provider notification, Abuse and Neglect, and Resident Rights, beginning	12/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 684	Continued From page 9 A review of the facility's policy titled, "Notification of Change in Condition," dated 12/16/2020, revealed, "The Center is to promptly notify the Patient/Resident, the attending physician and the Resident Representative when there is a change in the status or condition. Procedure: The nurse is responsible for notifying the attending physician and Resident Representative when there is a(): ...Significant change in the patient/resident's physical, mental or psychosocial status ... The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. The nurse will contact the physician. In the event the attending physician does not respond in a reasonable amount of time, the Medical Director must be contacted. If the Medical Director does not respond, call 911 and document in the medical record ... Document notification in the medical record ..." On 11/25/24 at 9:00 AM, during an interview, Resident #1's son stated he visited his mother on 11/05/24 and noticed she was weak, fatigued, and not eating. He reported his concerns to the former Administrator on 11/06/24 but felt no action was taken. He also spoke to the nurse on 11/07/24 about his concerns. On 11/08/24, he texted the Social Worker and requested the facility send his mother to the hospital. He stated the ambulance team informed him his mother was "dying slowly of constipation, dehydration, and a possible slight heart attack." A record review of the "Office/Clinic Notes" written regarding the 11/08/2024 admission to the local hospital revealed Resident #1 was admitted to the facility related to constipation with generalized weakness, poor appetite in addition to lower abdominal pain for four (4) days. CT (Computed	F 684	on November 26, 2024, by Unit Manager. * Monitoring began on November 26, 2024, by Director of Nursing (DON). The Director of Nursing will monitor bowel movement records weekly for three (3) weeks then monthly times three (3) months. Findings will be brought to the Quality Assurance Performance Committee Meeting monthly for three months beginning on December 20, 2024, by the Director of Nursing to determine the effectiveness and make necessary changes as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 684	Continued From page 10	F 684		

Tomography) of the abdomen on admission revealed markedly increased left colonic and rectal fecal content consistent with severe impaction with associated right hydronephrosis, distal mesenteric small bowel distention. Further review of the facility notes regarding the care of Resident #1 revealed "Diagnoses for this Visit" as Constipation, Dehydration, Hypokalemia, Hypotension Disorder of Kidney and Ureter, Urinary Tract Infection, and Altered Mental Status.

On 11/26/2024 at 9:00 AM, during an interview Licensed Practical Nurse (LPN) #1 confirmed she observed hard stool in Resident #1's rectum on 11/06/2024 and 11/07/2024 while providing wound care. She stated she administered MiraLAX and Lactulose but did not directly contact the Nurse Practitioner (NP), instead documented the issue in the NP's notification book.

A record review of the "Progress Notes" and "Nurse's Notes," dated 11/07/2024, revealed no documentation of a possible impaction or administration of MiraLAX and lactulose.

A record review of the "Physician's Orders" and "Medication Administration Record (MAR)" for November 2024 revealed no documentation of MiraLAX or Lactulose until 11/15/2024, after the resident returned from the hospital.

On 11/26/2024 at 10:15 AM, during an interview, the NP stated she checked her notification book and found no entry regarding a possible impaction. She confirmed she was not informed of Resident #1's condition and stated she would have ordered a Kidney, Ureter, and Bladder (KUB) X-ray had she been notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

(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 684	Continued From page 11 On 11/26/2024 at 11:00 AM, during an interview, the Director of Nursing (DON) confirmed there was no documentation indicating the NP or Medical Director was informed of the resident's possible impaction. She acknowledged LPN #1 failed to notify the appropriate providers as required. A review of Resident #1's "Admission Record" revealed the resident was admitted to the facility on 02/12/2014 with diagnoses that included Constipation, Chronic Pain, Muscle Weakness, and Heart Failure. A review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.	F 684		