STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24GC	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

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M 000	Initial Comments The State Agency (SA) conducted 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. During the survey, the the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements related to CI MS #27078 and cited M500. There were no citations related to CI MS #27005.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		12/20/24

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M 500	Continued From page 1 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

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M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III	M 500	M 500	

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M 500	Continued From page 4 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, whether alleged, suspected, or observed ..."	M 500	*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 three (3) months. Findings will be brought to the Quality Assurance Performance Committee Meeting monthly times three month by the Director of Nursing beginning December 20, 2024 to determine effectiveness and make necessary changes as indicated.	

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M 500	Continued From page 5 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 on 11/15/2024.	M 500		

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M 500	Continued From page 6 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 notification book and found no entry regarding the issue.	M 500		

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M 500	Continued From page 7 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.	M 500		