STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	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 two (2) Complaint Investigations (CI MS #27410 and CI MS #27422), at the facility from 1/17/25 through 1/27/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #27410 was investigated for neglect, accidents, falls, and no deficiencies were cited related to the investigation. CI MS #27422 was investigated for neglect, safety, and accidents and F689 and F865 was cited. The facility held a license for 73 beds and had a census of 54 at the time of the survey.	F 000		
F 689 SS=G	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 staff interview, record review, and facility policy review, the facility failed to ensure a resident's safety during a bed bath, in which Resident #2 fell from the bed to the floor, sustaining fractures to her bilateral lower extremities for one (1) of four (4) residents reviewed for falls. Findings Include:	F 689	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. 1. Resident # 2 was assessed by	2/13/25

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

Electronically Signed | 02/10/2025

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F 689	Continued From page 1 A review of the facility's policy titled "Accidents and Incidents", undated, revealed "It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible ..." A record review of the facility's investigation of Resident #2's fall with fractures revealed that on 12/21/24 at approximately 10:45 AM, Certified Nurse Assistant (CNA)# 1 provided care and a bath to Resident #2 while turning her in the bed on her left side. CNA#1 attempted to reach to hold onto the resident, but due to her being slippery, she rolled out of bed. A record review of the "Hospitalist Discharge Note", dated 12/22/24, indicated in the "Hospital Course" that Resident #2 was receiving a bath when she fell from the bed onto her knees, suffering bilateral femoral fractures ..." During a phone interview with CNA #1 on 1/22/25 at 3:30 PM, she confirmed that she was assisting Resident #2 with her bed bath. CNA #1 stated that Resident #2 helped during her bath because she could roll in the bed on each side, using the side rail. On that day, since she was slippery due to her bath, she could not catch her while turning. She accidentally fell to the floor on her knees while holding on to the siderail and "I could not catch her before she slipped off the bed." CNA #1 immediately notified the nursing supervisor and called for assistance for Resident #2. During a phone interview with Registered Nurse #1 on 1/27/25 at 10:00 AM, she revealed on 12/21/24 that CNA #1 summoned her to Resident	F 689	Registered Nurse (RN) #1 on 12/21/24 and was sent out to the Emergency Room on 12/21/24 to be further evaluated. 2. All residents who receive bed baths in the facility have the potential to be affected by this practice. 3. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed in-services with staff on 12/22/2024 on Falls, Transfers, Bed Mobility, and Care Plans. The Minimum Data Set (MDS) Nurse completed an audit on 01/30/2025 to reassess all residents' tasks for accuracy of the level of assistance needed related to bed baths. The DON and ADON completed skills competencies with Certified Nursing Assistants (CNA) for Bed Baths that started on 01/27/2025 and will be completed on 02/12/25. The DON and ADON completed an in-service with CNAs on reviewing tasks in Point Click Care (PCC) related to Bed Baths on 02/03/2025. 4. The Transitional Care Unit (TCU) Manager, MDS Nurse, ADON, 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 during	

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F 689	Continued From page 2 #2, finding the resident on the floor next to her bed. CNA #1 stated that when she gave her a bed bath, the resident was slippery and fell to the floor, and she could not catch her from falling. Resident #2 complained of bilateral knee pain and the nurse immediately phoned the local emergency medical response. Then she notified the medical provider, Resident Representative (RR), Director of Nursing (DON), and the Administrator. On 1/27/25 at 10:30 AM, during an interview with the DON, she confirmed that she was aware of the fall that occurred with Resident #2 on 12/21/24. The DON stated she immediately began an investigation, and all notifications were made. The DON confirmed that Resident #2 was able to assist with bed mobility for turning and repositioning in her bed for bed baths. The DON stated "the fall was an accident" due to Resident #2 being wet and slippery during the bed bath. On 1/27/25 at 10:45 AM, an interview with the Administrator confirmed that she was notified of the fall that occurred on 12/21/24 with Resident #2. She stated the facility investigated the allegation and ruled the fall as accidental. A record review of the "Admission Record" revealed the facility admitted Resident #2 on 3/27/24 and she had diagnoses including Atrial Fibrillation. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/25/2024 revealed Resident #2 had no impairment to her upper extremities, was not dependent for showering and bathing self, and was able to roll left and right with partial/moderate	F 689	bed baths to ensure safety. The TCU Manager, MDS Nurse, ADON, DON, or Administrator will complete audits to begin on 01/21/25, to include two (2) Residents weekly for 30 days; then two (2) Residents 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 during bed baths. Any concerns related to accidents and 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 April 27, 2025. The first QAPI meeting to review such audits will be held on February 12, 2025. 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 02/13/2025.	

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F 689	Continued From page 3 assistance.	F 689		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal	F 865		2/13/25

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F 865	Continued From page 4	F 865		

surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately

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F 865	Continued From page 5 resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure its Quality Assurance Performance Improvement (QAPI) program effectively addressed and prevented the recurrence of resident accidents. This failure resulted in a resident sustaining bilateral fractures, despite a prior citation for F689 on 10/3/24, which indicates the facility did not sustain systemic corrective actions to prevent the recurrence for one (1) of four (4) sampled	F 865	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. 1. Concerns identified through audits	

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F 865	Continued From page 6 residents. Resident #2. Findings Include: A review of the facility's "Quality Assurance and Performance Improvement (QAPI) Program" dated 10/22, revealed, " ...The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents ..." A record review of the Centers for Medicare and Medicaid Services (CMS) Form 2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), dated 10/3/24, revealed the facility was cited F689 (Accident Hazards) when two Certified Nurse Aides (CNAs) improperly positioned a resident in bed, resulting in a fall with an injury. A record review of the facility's investigation of Resident #2's fall with fractures revealed that on 12/21/24 at approximately 10:45 AM, Certified Nurse Assistant (CNA)# 1 provided care and a bath to Resident #2 while turning her in the bed on her left side. CNA#1 attempted to reach to hold onto the resident, but due to her being slippery, she rolled out of bed. During an interview with the Director of Nurses (DON) on 1/27/25 at 11:00 AM, she confirmed she reviewed the CMS-2567 from the survey on 10/3/24. She stated the facility continued to conduct audits to monitor compliance of residents having a safe environment and to prevent accidents as per the plan of correction.	F 865	and observations will be presented at the next monthly Quality Assurance Performance Improvement (QAPI) Meeting for review on February 12, 2025. 2. All residents in the facility have the potential to be affected by this practice. 3. The Administrator completed an in-service on 02/07/2025 with the interdisciplinary team members on QAPI policy and procedure, reporting of concerns and trends identified through observations and audits, and action plans are developed and effectively addressed. 4. The Administrator will oversee the QAPI Program and will review active audits, observations, and plan of corrections (POC) and ensure feedback from the Interdisciplinary Team is incorporated into plans in QAPI Meeting monthly to ensure the program effectively addresses action plans to sustain systematic corrective actions necessary to prevent accident reoccurrences. Any concerns related to QAPI 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 April 27, 2025. The first QAPI meeting to review such audits will be held on February 12, 2025. 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	

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F 865	Continued From page 7 During an interview with the Administrator on 1/27/25 at 11:20 AM, the facility performed audits to monitor the residents for safety and accident prevention. She commented that she was going to take the concerns regarding accident/hazards back to the (QAPI) committee to again develop action plans and audits.	F 865	complete further in-service education. 5. Completion date as of 02/13/2025.	