MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30SR | 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) COMPLETE DATE |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted two (2) Complaint Investigations (CIs), MS #27410 and 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #27410 was investigated for neglect, accidents, fall, and no deficiencies were cited related to the investigation. CI MS #27422 was investigated for neglect, safety, and accidents and M640 was cited. | M 000 | | |
| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level III<br><br>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.<br><br>Findings Include:<br><br>A review of the facility's policy titled "Accidents and Incidents", undated, revealed "It is the policy of this facility that the resident environment | M 640 | 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.<br><br>1. Resident # 2 was assessed by Registered Nurse (RN) #1 on 12/21/24 and was sent out to the Emergency Room on 12/21/24 to be further evaluated.<br><br>2. All residents who receive bed baths in | 2/13/25 |

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| M 640 | Continued From page 1<br>remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible ..."<br><br>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.<br><br>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 ..."<br><br>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.<br><br>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 #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. | M 640 | the facility have the potential to be affected by this practice.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 bed baths to ensure safety.<br><br>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) | |

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| M 640 | Continued From page 2<br><br>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.<br><br>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.<br><br>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.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #2 on 3/27/24 and she had diagnoses including Atrial Fibrillation.<br><br>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 assistance. | M 640 | 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.<br><br>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.<br><br>5. Completion date as of 02/13/2025. | |