STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASS CHRISTIAN HEALTH AND REHABILIATION CENTER	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

(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 (CI) MS #28428, CI MS #28469, CI MS #28678, CI MS #28690, and CI MS #28766, at the facility from 4/29/25 through 5/1/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS#28690 was investigated for nursing services, medication not given according to physician instructions, and facility not clean and F684 was cited. CI MS #28428 was investigated for nursing services with no deficiencies cited. CI MS #28469, CI MS #28678, and CI MS #28766 was investigated for staffing with no deficiencies cited. The facility held a license for 60 beds and had a census of 54 at the time of the survey.	F 000		
F 684 SS=E	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 review, and facility policy review, the facility failed to administer intravenous (IV) antibiotics for Resident #1 as ordered for two (2) of three (3) scheduled doses.	F 684	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conslusions set forth in the	5/22/25

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

Electronically Signed | 05/15/2025

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F 684	Continued From page 1 Findings Include: Review of the facility's policy, "Physician Orders," revised 3/3/2021, revealed, " ...The center will ensure that Physician orders are appropriately and timely documented in the medical record ..." Review of the facility's policy, Administering Medications," revised April 2019, revealed, "Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation ...4. Medications are administered in accordance with prescriber orders, including any required time frame ...7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified ...21. If a drug is ...given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose ..." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 3/28/25 with diagnoses including Sialoadenitis and Bacteremia. Record review of the "Order Summary Report" revealed Resident #1 had a Physician's Order, dated 3/28/25, for "ceFAZolin Sodium Intravenous Solution Reconstituted 2 GM (Grams) ...Use 2 gram intravenously every 8 (eight) hours for parotitis; sepsis ..." Record review of the "Electronic Medication Administration Record (EMAR)" revealed Resident #1 received one (1) dose of Cefazolin Sodium 2 grams IV on 3/29/25 at 0600 (6:00 AM),	F 684	Statement of Deficiencies. This Plan of Correction is prepared solely because of the provisions of State and Federal Laws. 1) Root Cause Analysis was conducted by Interdisciplinary Team (IDT) and based on findings. Corrective action was taken with Registered Nurse Assigned to administer Intravenous Medication for Resident #1. Resident #1 was discharged to the hospital on 3/29/25 at 9:10pm. 2) Residents with an order for Intravenous Medications have the potential to be affected. Audit was conducted by Director of Nursing on 5/1/2025 of Residents with physician orders for Intravenous Medications to ensure medications administered according to the physician orders. 3) Education with the Licensed Nurses was conducted on 5/1/2025 by the Director of Nursing regarding administering Intravenous Medications in a safe timely manner according to the physician order. Intravenous Medications will be administered by a Registered Nurse. In the event the Registered Nurse cannot administer the Intravenous Medication according to the physician order the Executive Director or Staffing Coordinator will be notified. New hires will be educated in orientation. 4) Director of Nursing (DON) or Unit Manager will conduct Quality Monitoring beginning 5/1/25 of the Electronic Medication Administration Record with a	

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F 684	Continued From page 2 and the scheduled doses for 3/28/25 at 2200 (10:00 PM) and 3/29/25 at 1400 (2:00 PM) were not documented as administered. Record review of the Omnicell medication dispensing record revealed Cefazolin (1 gram × 2 vials) was removed from emergency stock on 3/29/25 at 10:12 AM by the Director of Nursing (DON). The facility's Omnicell showed pre-stocked Cefazolin 1 gram vials available in emergency stock. Record review of the "Progress Notes" revealed a "General Progress Note", dated 3/28/25 at 19:35 (7:35 PM) for Resident #1, which documented "Resident arrived to facility at approx (approximately) 1830 (7:30 PM). A "General Progress Note", dated 3/29/25 at 21:29 (9:29 PM) for Resident #1 revealed, " ...IV ATB (Antibiotics) unable to be administered at 2 gm IM (Intramuscular), this writer informed resident and her daughter, per daughter resident needs sent to ER (Emergency Room) to receive ATB ..." On 4/29/25 at 10:30 AM, during a phone interview with Resident #1's Resident Representative (RR), she stated Resident #1 did not receive any of the prescribed antibiotics until mid-morning on 3/29/25, and that no further doses were administered. The family requested the resident be transferred back to the local hospital on 3/29/25 later that night so that she could receive her IV antibiotics at the correct times. On 4/29/25 at 2:16 PM, during an interview, the former DON confirmed that although she intended to administer the 10:00 PM dose on 3/28/25, due to personal circumstances, she did not administer that dose and did not inform the	F 684	sample of five Residents three times weekly for one month then twice weekly for two months to ensure Intravenous Medications are administered as ordered by the physician. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 5/19/25 for three months.	

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F 684	Continued From page 3	F 684		

Administrator. She acknowledged giving the 3/29/25 6:00 AM dose late, at approximately 10:12 AM but documented the dose on the MAR incorrectly as administered at 6:00 AM. She further stated that the 2:00 PM dose on 3/29/25 was not administered.

On 4/30/25 at 9:00 PM, during an interview, the Nurse Practitioner (NP) confirmed that IV antibiotics ordered every 8 hours must be administered as prescribed. She stated that missed or delayed doses could contribute to delayed recovery and increased patient suffering.

On 4/30/25 at 2:16 PM, during an interview, the Interim DON confirmed that although she was not present at the time of the incident, the facility's policies require timely medication administration by licensed staff. She confirmed the EMAR and Omnicell record showed only one (1) dose given before the resident's transfer to the ER and acknowledged that the 6:00 AM dose was signed as given but not administered until 10:12 AM, constituting a late and improperly documented dose. She stated this failure violated the facility's expectations and placed the resident at risk for delayed treatment and prolonged infection. The Interim DON also confirmed that the resident's family requested the resident be transferred to the hospital due to the facility's inability to administer the IV antibiotics on schedule.