STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	**1199 OCEAN SPRINGS ROAD , OCEAN SPRINGS, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), MS #2607101 and CI MS #497417 at the facility from 9/08/25 through 9/11/25. The SA investigated CI MS #2607107 for a resident-on-resident incident. The SA investigated CI MS #497417 for misappropriation of funds. There were no citations related to the CIs. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F557, F561, F572, F583, F607, F677, F732, F812, F851, F867 and F880. The facility held a license for 115 beds, with a census of 108.	F0000		10/08/2025
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident's right to dignity and respect when staff required her to wear a brief against her preference instead of providing a bedpan or assistance to the bathroom for one (1) of (22) sampled residents, Resident #109. Findings include: On 9/9/25 at 11:05 AM, in an interview, Resident #109 reported that the night shift staff told her she would need to wear a brief rather than being assisted to the	F0557	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident #109 was notified on 09/11/2025 by the Social Services Director of her right to have toileting assistance provided in a manner of her wishes. 2) Residents that require toileting assistance have the potential to be affected. 3) Education was provided by the Unit Manager with Licensed Nurses and Certified Nursing Assistants that Residents have the right to have their dignity maintained in choosing how they toilet. Residents that prefer to use a bed pan will have that right honored. Residents will be evaluated for toileting assistance on admission and interviewed as to their preferences. Residents that can tolerate use of a bed pan and prefer to use a bed pan will be provided a bed pan. New hires will be educated in orientation upon hire. 4) Quality Monitoring will be conducted beginning 09/15/2025 by the Director of Nursing, Licensed Nurses or Unit Manager to ensure Residents have been evaluated for toileting preferences. This sample will be 10 cognitive residents requiring incontinent care 2 times a week for 4 weeks then weekly for 2 months. Findings	10/08/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0557 SS = D	Continued from page 1 bathroom or put on a bedpan, despite her reporting that she does not wear briefs. On 09/10/2025 at 4:15 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that Resident #109 was already admitted to the facility when she came on shift and she recalled that she thought the resident was wearing a pull-up at that time, and she suggested that a brief might be easier than a pull-up since it would not require pulling up and down. LPN #1 confirmed that the evening shift staff, including herself, used a bedpan for the resident, and she personally assisted the resident onto the bedpan, which she tolerated well. She stated she did not know why the night shift staff chose not to use the bedpan and instead placed the resident in a brief. On 09/11/2025 at 11:00 AM, during a follow-up interview with Resident #109 and her daughter, both explained that when the resident was admitted to the facility, she was not wearing a pull-up or a brief. The daughter stated she dressed the resident at the hospital and confirmed she was wearing panties with an incontinence pad for accidents. The resident reported she continues to wear panties and does not want to feel degraded or disrespected by being asked to wear a brief. She emphasized that she never requested either a brief or a pull-up. The resident explained that when staff attempted to place a brief on her, she objected and only stated that if staff insisted, a pull-up would be preferable to a brief. On 09/11/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained that she does not expect any staff to place a brief or pull-up on a resident who is continent, as this is both a resident rights and dignity issue. A record review of the “Admission Record” revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery. A record review of the “BIMS” (Brief Interview for Mental Status) document, with an “Effective Date” of 09/10/2025 revealed Resident #109 was cognitively intact.	F0557	Continued from page 1 will be reported to the Quality Assurance and Performance Improvement Committee monthly beginning 10/01/2025 for 3 months or until substantial compliance is met.	
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F0561	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident #48 was born in South Korea, and the Social Services Director contacted the Korean Consulate on 09/18/2025 for assistance in obtaining a Resident Identification Card.	10/08/2025

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F0561 SS = D	Continued from page 2 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to honor a resident's request for assistance in obtaining personal identification, resulting in a delay of more than one (1) year without follow-up affecting her autonomy and ability to exercise her rights related to personal identification and community access for (1) of (22) sampled residents, Resident #48. Findings include: On 9/8/25 at 12:31 PM, in an interview, Resident #48 stated she had requested assistance from the facility in completing paperwork and obtaining a state identification (ID) card but that her request had not been fulfilled. On 9/10/25, at 8:34 AM, during an interview, the Social Services Director stated she had no knowledge of Resident #48's request for assistance with obtaining an ID. She reported the resident frequently brought her insurance mail but had not made the ID request directly to her, acknowledging that the resident may have told	F0561	Continued from page 2 2) Residents who want to obtain a personal identification card or community access have the potential to be affected. 3) Education was provided by the Regional Director of Clinical Services with all staff that Residents have a right to have their request to obtain a personal state identification care or community access honored. Social Services will assist Residents in their request to obtain a personal identification care when requested to include transportation. New hires will be educated in orientation upon hire. 4) Quality Monitoring by interview of Residents will be conducted beginning 09/15/2025 by the Social Services Director or Activities Director with a sample of 10 residents 2 times a week for 4 weeks then weekly for 2 months to ensure assistance has been provided per Residents request to obtain a personal state identification care or community access. Finding will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0561 SS = D	Continued from page 3 the Social Services Assistant instead. On 9/10/25 at 10:50 AM, during an interview, Social Services Assistant (SSA) #1 recalled Resident #48 previously requested transportation to the Department of Motor Vehicles (DMV) to renew her license and obtain a state ID. SSA #1 stated the resident's out of state driver's license and state ID were expired, and the resident was informed that a birth certificate was required. SSA #1 reported the request had not been resolved due to turnover in the social services department and lack of follow-up from the prior Social Worker. She confirmed the resident had been transported to multiple DMV locations but was unsuccessful each time because she did not have a birth certificate. SSA #1 explained that the resident would need to apply for a birth certificate through another country's embassy before the ID could be obtained. On 9/10/25 at 4:45 PM, during a follow up interview, the Social Services Director confirmed that the SSA had knowledge of the process to obtain a birth certificate and acknowledged that the matter had not been resolved for Resident #48. On 9/11/25 at 5:25 PM, during an interview with the Administrator, he revealed his expectations for the Social Services Department are to ensure resident requests are honored. A record review of the "Admission Record" revealed the facility initially admitted Resident #48 on 8/21/2014 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/8/25, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.	F0561		
F0572 SS = D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of	F0572	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Residents Bill of Rights was reviewed and a copy provided to Resident #26 in writing on 09/12/2025 by the Admissions Coordinator. 2) All Residents have the potential to be affected. 3) Education was provided by the Ombudsman with all staff that Residents will have the Residents Bill of Rights reviewed with them and a copy provided to them in writing. Residents Bill of Rights will be provided	10/08/2025

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F0572 SS = D	Continued from page 4 rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and resident council interview, the facility failed to provide residents or their resident representatives (RRs) with copies of the Resident Bill of Rights and admission documents at the time of admission, with the potential to affect all newly admitted residents by depriving them of required information about their rights and responsibilities upon admission for one (1) of 22 sampled residents (Resident #26). Findings include: A review of the facility's "Admission Agreement" revised 5/25, revealed that Section #20 (items a–o) requires residents or their representatives to sign acknowledging receipt of copies received including the Resident Bill of Rights, Resident Handbook, and other admissions documents. On 9/8/202 at 2:00 PM, during a resident council meeting, Resident #26 stated she did not recall receiving admission information during the admission process. She stated she was admitted to the facility on 8/30/25. On 9/10/25, at 4:45 PM, an interview with the admissions Coordinator, who has been employed in the position since January 2025, revealed that she has not provided residents or their representatives with a copy of the Resident Bill of Rights or the resident handbook during the admission process. She stated that since the facility's recent acquisition, staff have not been able to order resident handbooks and that resident rights documents were not available to distribute. She acknowledged that although residents and representatives signed the admission agreement	F0572	Continued from page 4 of all Residents and/or Resident Representative upon admit by the Admissions Coordinator or Social Servies. All new hires will be educated in orientation upon hire. 4) Quality Monitoring by interview of Residents will be conducted with a sample of 10 Residents 2 times a week for 4 weeks and then weekly for 2 months beginning 09/15/2025by the Social Service Director, Admission Coordinator and/or the Director of Nursing to ensure the Residents Bill of Rights are provided to the Residents and/or Resident Representative upon admit. Findings will be reported to the Quality Assurance and Performance Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0572 SS = D	Continued from page 5 acknowledging receipt of the items, she had no materials available to provide. On 9/11/25, at 12:23 PM, during a follow up interview, Resident #26 stated she admitted herself and did not recall receiving a folder with signed admission documents unless her daughter may have taken it. On 9/11/25, at 12:46 PM, the Resident #26's emergency contact and relative stated that no admission paperwork was sent home with her following Resident #26's admission. On 9/11/25, at 2:58 PM, the Admissions Director stated she had completed Resident #26's admission paperwork face-to-face on a Saturday. She recalled verbally explaining the documents but admitted she did not provide physical copies to the resident because she did not have access to a copier in the field. She confirmed that Resident #26 did not receive any admission documents during the admission process. Record Review of the "Admission Record" revealed the facility admitted Resident #26 on 8/30/2025 with diagnoses including Surgical Aftercare following Surgery on the Nervous System. Record review of Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/6/2025, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	F0572		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to	F0583	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Personal private Hospice information was removed from Resident #85's door on 09/11/2025. Education with the Hospice Nurse that placed the signage on door was conducted on 09/11/2025. 2) All Residents receiving hospice care have the potential to be affected. 3) Education was provided by the Executive Director and The Director of Nursing with all staff and Hospice staff that Residents have the right to personal privacy and not have personal private information posted. Residents personal and private information will not be posted in a manner that will void Residents rights to privacy. Any signage with Residents personal or health information will not be posted on Resident doors, walls or rooms. All new hires will be educated in orientation upon hire.	10/08/2025

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F0583 SS = D	Continued from page 6 privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to personal privacy by posting identifying hospice information on a resident's door for one (1) of 22 sampled residents. Resident #85. Findings include: A review of the facility's policy, "Resident Rights" dated 11/30/2014, revealed "… The Facility will not use or disclose the resident's health information without the Resident's authorization…" On 9/8/25 at 10:26 AM, during an observation of Resident #85's room, signage was posted on the resident's door sign labeled "(Proper Name of Hospice Provider)" with the resident's first initial and last name highlighted in yellow stated "Call (Proper Name of Hospice Provider) First." Resident #85 was lying in bed and was unable to verbalize awareness of hospice services or knowledge of the signage posted on her door. On 9/8/25 at 12:40 PM, during a phone interview with Resident #85's resident representative (RR), she reported that she had not requested the hospice sign to be placed on her mother's door. She explained that the sign was placed there by the hospice provider. On 09/10/2025 at 1:20 PM, during an interview and	F0583	Continued from page 6 4) Quality Monitoring by observation will be conducted with a sample of 10 rooms 2 times a week for 4 weeks then weekly for 2 months beginning 09/15/2025 by the Director of Nursing, Unit Manager or Licensed Nurse to ensure Residents private information is not posted in site or any signage posted with Residents private information. Findings will be reported to the Quality Assurance and Performance Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0583 SS = D	Continued from page 7 observation with the Hospice Coordinator, she confirmed the sign posted on Resident #85's door regarding hospice services and acknowledged she was aware that signage disclosing resident-specific health information should not be posted. She confirmed the sign was clearly visible to anyone passing by the room. She stated she did not authorize the posting of the signage and had not been informed that it had been placed. On 09/10/2025 at 1:50 PM, during an interview with the Director of Nursing, she stated she was not aware that a hospice sign had been posted on Resident #85's door. She explained that staff are trained and aware that resident privacy must be protected and that personal health information should not be displayed. She was unsure whether hospice staff or another individual placed the sign. She stated it is her expectation that staff would notify her immediately if any signage containing resident-specific health information is posted, and that such signage be removed right away. On 09/11/2025 at 02:40 PM, during an interview with the Administrator, he confirmed he had been informed that Hospice had placed a sign on a resident's door. He explained there should never be any posting of signage containing resident-specific health information, as this violates a resident's right to privacy and dignity. A record review of the "Admission Record" revealed the facility admitted Resident #85 on 10/16/24 with current diagnoses including Dementia. A record review of Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/25 revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident's cognition was severely impaired. A review of Section O revealed she was receiving hospice care. A record review of the "Order Summary Report" revealed Resident #85 had a Physician's Order, dated 1/30/25, to admit the resident to hospice services.	F0583		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F0607	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident's misappropriation was reported to the appropriate state agency by the Executive Director on 07/03/2025. 2) Residents with allegations of misappropriation have the potential to be affected.	10/08/2025

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F0607 SS = D	Continued from page 8 resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, facility investigation and facility policy review, the facility failed to implement its abuse prevention policy by not reporting and investigating an allegation of misappropriation of resident property in a timely manner for one (1) of 22 sampled residents, Resident #106. Findings Include: A review of the facility's policy, "Abuse, Neglect, Exploitation and Misappropriation", revised 11/16/2022, revealed, "…7. Reporting/Response: Any employee or contracted service provider who…has knowledge of…an allegation of…misappropriation of resident property…is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse…Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and	F0607	Continued from page 8 3) Education was provided by the Regional Director of Clinical Services on 09/11/2025 with the Executive Director and Director of Nursing on Abuse, Exploitation, Misappropriation and Neglect Policy with emphasis on reporting and investigating. Education was provided by the Regional Director of Clinical Services on Abuse, Exploitation, Misappropriation, and Neglect Policy with emphasis on misappropriation reporting and investigating allegations of misappropriation will be reported to the nursing supervisor, executive director and director of nursing within two hours. An investigation will be conducted of the allegation and a final report summary submitted to the state agency within 5 days. New hires will be educated in orientation upon hire. 4) Quality Monitoring will be conducted upon occurrence beginning 09/15/2025 of any allegations of abuse, exploitation, misappropriation or Neglect by the Executive Director and/or the Director of Nursing to ensure reporting and investigation in accordance with state and federal regulations. Findings will be reported to the Quality Assurance and Performance Improvement Committed monthly beginning 10/01/2025 for 3 months or until substantial compliance is met.	

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F0607 SS = D	Continued from page 9 appropriately to appropriate officials in accordance with Federal and State regulations … Review of report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State Law, including to the State Agency, within 5 working days of the incident …" A record review of the facility's investigation emailed to the SA on 7/3/25, revealed, "…Please accept this email as formal, initial notification of misappropriation of funds that occurred on June 27, 2025..." The investigation detailed that on 6/27/25, Resident #106 reported Certified Nursing Assistant (CNA) #1 was seen handling her change purse and that coins were missing. The record further showed the incident was not reported timely to the State Agency (SA) as required by facility policy. On 9/10/25 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #2, she explained that on 6/27/25, while providing wound care to Resident #106, she turned the resident and noticed quarters stuck to her back and a small red change purse tucked inside her gown. LPN #2 stated the resident typically kept the change purse on her overbed table. When she asked the resident about it, the resident reported she had been napping earlier that morning, awoke to a noise, and observed Certified Nursing Assistant (CNA) #1 at her bedside with her change purse open and removing quarters. The resident told LPN #2 she believed money was missing. LPN #2 stated she immediately reported the allegation to the charge nurse on duty, who then reported it to the Director of Nursing (DON). On 9/11/25 at 10:50 AM, during an interview with the DON, she explained that the incident was not reported within required timeframes because leadership initially debated the credibility of the allegation. She confirmed that the allegation should have been reported immediately, in accordance with facility policy, and acknowledged that the delay was a violation of the policy. On 9/11/25 at 11:25 AM, during an interview with the Administrator, he confirmed he did not initially report the allegation because the resident stated she did not want to make a big deal about it. He acknowledged awareness of the facility's policy requiring all allegations of abuse or misappropriation to be reported immediately. A record review of the "Admission Record" revealed the	F0607		

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F0607 SS = D	Continued from page 10 facility admitted Resident #106 to the facility on 7/16/2023 with current diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an ARD of 07/08/2025 revealed Resident #106 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated she was cognitively intact.	F0607		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for residents who are dependent upon staff, related to incontinence care (Resident #109) and shaving (Resident #91) for two (2) of 22 sampled residents. Findings include: A review of the facility's policy, "Activities of Daily Living (ADLS)" dated 02/01/2022, revealed "… To encourage resident choice and participation in activities of daily living (ADL) and provide…assistance as necessary … ADLs includes bathing, dressing, grooming, hygiene, toileting … Procedure…2. CNA (Certified Nurse Aide) will provide needed … assistance to resident…" Resident #109 On 9/9/25 at 11:05 AM, during an interview, Resident #109 reported she had been left in a soiled brief since 6:00 AM. She stated she pushed the call light several times, but staff turned the light off without returning to provide care. The resident's daughter, present at the time, confirmed she arrived at 9:00 AM, remained until 10:10 AM, returned at 10:30 AM, and no staff had checked on or changed the resident during that time. On 9/9/25 at 11:30 AM, during an interview, Certified Nursing Assistant (CNA) #1 reported she had not checked on or changed Resident #109 during her shift and stated she had been told in report that the resident went to the bathroom independently. She acknowledged she was	F0677	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident #91 was shaved by Certified Nursing Assistant (CNA) #1 on 09/09/2025 and Resident #109 was provided incontinent care by CNA #1 on 09/09/2025. 2) Residents that require staff assistance with Activities of Daily Living (ADL) care have the potential to be affected. 3) Education was provided by the Unit Manager and the Director of Nursing with all Licensed Nurses and Certified Nursing Assistants on providing ADL care to include incontinence care and shaving for Residents that need assistance. Staff will provide encouragement of Residents for ADL care and incontinent care when indicated. All new hires will be educated in orientation upon hire. 4) Quality Monitoring by Resident interview and observation will be conducted with a sample of 10 residents 2 times a week for 4 weeks then weekly for 2 months by observation and interview beginning 09/15/2025 by the Director of Nursing, Unit Manager or Licensed Nurse to ensure Residents are receiving ADL care to include incontinent care and shaving as needed. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	10/08/2025

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F0677 SS = D	Continued from page 11 not familiar with the resident. On 9/9/25 at 11:45 AM, during an observation, CNA #1 checked Resident #109 and confirmed her brief was saturated, and the bed was soiled, requiring a complete bed change. On 9/9/25 at 11:50 AM, during an interview, the facility Ombudsman stated the facility had received numerous complaints from residents being left in soiled briefs for long periods of time. On 09/11/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained all staff are to be aware of residents' needs to provide the appropriate quality of care for each resident and that a resident left in a soiled brief for hours is not acceptable. A record review of the "Admission Record" revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery. Resident #91 On 9/8/25 at 11:11 AM, during an observation, Resident #91 was lying in bed watching television. Thick facial hair was noted on the resident's chin and neck. The resident stated she liked to have her facial hair shaved but staff often forgot to do so. On 9/9/25 at 4:15 PM, during an observation, Resident #91 remained with long facial hair. She stated she disliked having facial hair, but that staff forgot to shave her. On 9/9/25 at 4:30 PM, during an interview, CNA #2 explained Resident #91 was a day-shift shower/bath resident and female residents were supposed to be shaved on shower days. She stated whether Resident #91 was shaved was dependent upon the CNA assigned and acknowledged the resident currently had long facial hair. CNA #2 stated Resident #91 was always cooperative and did not refuse care. On 9/10/25 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #2 stated she noticed Resident #91 with long facial hair both the previous day and that morning. She explained that CNAs were instructed and in-serviced to provide shaving during bathing or shower care. She confirmed Resident #91 did not refuse care and was cooperative.	F0677		

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F0677 SS = D	Continued from page 12 On 9/10/25 at 2:10 PM, during an interview, the DON stated residents were to be shaved during ADL care, including women. She stated a female resident with long facial hair on her chin was not acceptable and staff were expected to provide the needed care. On 09/11/2025 at 2:30 PM, during an interview with the Administrator, he confirmed that residents left sitting in urine or not receiving timely care was unacceptable and not consistent with facility practices. He stated he expects all residents who are dependent on staff for ADLs to be treated in a dignified manner. He further explained that if staff observe long facial hair, especially on a female resident, it is their responsibility to provide shaving unless the resident refuses, in which case the refusal must be documented in the record. A record review of the “Admission Record” revealed the facility admitted Resident #91 on 11/16/22 with diagnoses including Paraplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #91 was dependent on staff for personal hygiene, toileting, and bathing.	F0677		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F0732	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Posted staffing relocated to a prominent area that is accessible by all residents and visitors. 2) All Residents have the potential to be affected. 3) Education was provided by the Director of Nursing with all Licensed Nurses on the requirement of posting actual hours worked by direct care staff responsible for Residents care. Staffing will be posted in a prominent area that is accessible to residents and visitors. Nursing Supervisor will post staffing at the beginning of the shift indicating staff present providing direct resident care. New hires will be educated in orientation upon hire. 4) Quality Monitoring by observation will be conducted 5 times a week for 3 months beginning 09/15/2025 by the Director of Nursing and Staffing Coordinator to ensure staffing is posted with actual direct care hours in a	10/08/2025

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F0732 SS = C	Continued from page 13 (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to post daily nurse staffing information in a prominent place readily accessible to residents, staff, and visitors for four (4) of (4) days of survey, which had the potential to affect all 108 residents residing in the facility. Findings include: On 9/8/25 at 10:00 AM, during an initial tour of the facility, there was no daily staffing information posted throughout the building. There was a stop sign on the entranceway door asking staff and family not to allow residents beyond the double doors into the entrance hall. On 9/9/25 at 8:00 AM, during a walkthrough of the facility, the State Agency (SA) did not observe the required daily posting of staffing information. On 9/10/25 at 9:00 AM, during a walkthrough of the facility, the SA did not observe the required daily	F0732	Continued from page 13 prominent area accessible to Residents and visitors. Findings will be reported to the Quality Assurance and Performance Improvement Committee beginning 10/01/2025 for 3 months or until substantial compliance is met.	

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F0732 SS = C	Continued from page 14 posting of staffing information. On 9/11/25 at 11:55 AM, during an interview, Licensed Practical Nurse (LPN) #4 stated that the staffing was usually taped on the table in the entrance hallway next to the visitor sign-in book. LPN #4 confirmed she failed to tape the staffing information on the table on 9/8/25, but she did on 9/9/25 through 9/11/25. LPN #4 confirmed residents do not frequent the entrance hallway and acknowledged the sign on the door indicating, “Do not allow residents to go beyond this door.” LPN #4 stated she had not been posting the daily staffing in a place where all visitors, staff, and residents could see it. She stated she had been told to tape the daily staffing information on the table in the entrance hall daily but was not aware of the regulation requiring staffing to be posted in a prominent area where residents, family, and visitors could see it. On 9/11/25 at 3:30 PM, during an interview, the Administrator and the Director of Nursing (DON) both confirmed the daily staffing postings did not meet the regulatory requirements of being in an area accessible to residents. They confirmed there was a sign asking staff and visitors not to allow residents beyond the double doors into the entrance hall, which prevented residents from seeing the daily posted staffing information. The DON stated the Staff Development Nurse was responsible for posting the daily staffing, including all required information, and ensuring it was posted where everyone could see it. The Administrator and the DON confirmed residents did not frequent the entrance hall and stated they would place the staffing information in a glass case where it would be visible to everyone going forward.	F0732		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F0812	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Outdated food items and overly ripe foods were discarded, pantry flour bin lid was secured, and teriyaki and soy sauce was discarded on 09/08/2025 by the Dietary Manager. Pantry flour bin lid was secured. Teriyaki and Soy sauce was discarded. 2) All Residents have the potential of be affected. 3) Education was provided by the Dietary Manager on Food Storage and Procurement and Food Handling to maintain food quality and hygienic practices in accordance with professional standards of practice for food safety related to food storage, overly ripe foods, expired foods and unsanitary handling of ready-to-eat food. All new hires will be educated in orientation	10/08/2025

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F0812 SS = F	Continued from page 15 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain food quality and hygienic practices in accordance with professional standards for food safety related to overly ripened produce, improperly stored food, exposed food, expired food, and unsanitary handling of ready-to-eat food for two (2) of (2) kitchen observations. Findings include: A review of the facility's policy, "Sanitation Inspections, Nutrition, and Food Service," with an effective date of 11/30/2014, revealed, "…Each item is labeled and dated before refrigeration… Avoid indiscriminate handling of foods with fingers. The proper use of hands, gloves and serving utensils shall be taught to all food handlers..." On 09/08/2025 at 10:15 AM, during an observation and interview of the kitchen with the Dietary Manager (DM), Refrigerator #1 was observed to contain two (2) small plates with individual portions of lettuce, tomato, and onions that were not dated, and one (1) cut piece of overly ripe cucumber with dark spots. Refrigerator #2 was observed to contain four (4) bunches of overly ripe celery with withered leaves that were soft and flexible, one (1) opened bag of salad mix with a manufacturer's "Best if Used By" date of 9/4/25, and five (5) heads of iceberg lettuce with slimy dark leaves and visible white biological growth. The pantry was observed to have a flour bin with the lid left open, exposing the flour, and opened gallon-sized bottles of teriyaki sauce and soy sauce with manufacturer instructions to refrigerate after opening. The DM acknowledged the overly ripe produce, exposed and expired food, and improper storage. He stated he and the cook were responsible for maintaining food quality and that staff were in-serviced monthly on food safety.	F0812	Continued from page 15 upon hire. 4) Quality Monitoring by observation will be conducted with a sample of 5 observation 2 times a week for 4 weeks and then weekly for 2 months beginning 09/15/2025 by the Dietary Manager to ensure food quality and hygienic practices in accordance with professional standards of practice for food safety related to food storage, overly ripe foods, expired foods and unsanitary handling of ready-to-eat food. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0812 SS = F	Continued from page 16 On 09/09/2025 at 11:19 AM, during a follow-up observation of the kitchen service line and staff interviews with the Baker, she was observed preparing resident trays while picking up bread rolls and pieces of fried fish with her gloved hands, arranging chicken and potatoes on plates with her gloved hands. The Baker confirmed she was handling food with her gloved hands and acknowledged the importance of using sanitary practices to prevent cross-contamination. She stated staff received food safety in-services every two (2) weeks. During the same observation, a Dietary Aide (DA) was observed removing a serving spoon from a pan of potatoes, using it to push chicken from one plate to another, then using the same spoon to serve carrots. The DA was further observed placing bread rolls and pieces of fried fish on plates with her gloved hands. In an interview at this time, the DA acknowledged she had handled food with her gloved hands and confirmed she knew food should be handled with proper utensils. She stated staff received in-services on food safety every (2) months. The DM acknowledged the unsanitary handling of food observed during tray service. He stated his expectation was for staff to use utensils for ready-to-eat foods to prevent contamination and foodborne illness. He reported he would conduct additional staff training. On 09/11/2025 at 11:37 AM, during an interview, the Administrator acknowledged he was made aware of the observations of overly ripe produce, exposed food, expired food, and unsanitary food handling practices. He confirmed that it was the responsibility of the DM and Cook to maintain food safety standards and stated he would implement daily monitoring to ensure compliance.	F0812		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff.	F0851	1) Root Cause Analysis was conducted by the Quality Assurance Performance Improvement Committee on and based on the findings, the facility failed to ensure complete and accurate staffing data was submitted to the Centers for Medicare and Medicaid Services (CMS) through Payroll Based Journal (PBJ) reporting during Quarter 3 of Fiscal Year (FY) 2025 (April 1 - June 30). The facility reviewed and reconciled all staffing data for the affected reporting period and verified licensed nursing coverage for Quarter 3 FY 2025 (April 1 - June 30). 2) All Residents have the potential to be affected. 3) Education was conducted with the Executive Director,	10/08/2025

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F0851 SS = F	Continued from page 17 Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by:	F0851	Continued from page 17 Director of Nursing and Human Resources Director on the requirement of submitting direct care staffing hours electronically to CMS. The Executive Director or Director of Nursing and the Human Resources Director will jointly complete weekly reconciliation of hours worked versus hours entered into People Net and PBJ beginning 09/15/2025. New hires will be educated in orientation upon hire. 4) Quality Monitoring by observation and review will be conducted weekly for 4 weeks then monthly for 3 months beginning 09/15/2025 by the Executive Director or Director of Nursing and Human Resources Director to ensure accurate reporting of direct care hours versus hours entered into People Net and PBJ. Finding will be reported to the Quality Assurance and Performance Improvement Committee starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0851 SS = F	Continued from page 18 Based on record review and interview, the facility failed to accurately report staffing data to the Centers for Medicare and Medicaid Services (CMS) using payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, FY (Fiscal Year) Quarter 3 2025 (April 1-June 20) resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN) hours, and no licensed nursing coverage 24 hours/day. Findings include: A record review of the “Payroll Based Journal (PBJ) Staffing Data Report” for the third (3rd) quarter (4/1/25 through 6/30/25) revealed the facility triggered for “Excessively Low Weekend Staffing, No RN Hours, and Failed to Have Licensed Nursing Coverage 24 Hours/Day.” Further review revealed the “Infraction Dates” for No RN Hours and Failure to Have Licensed Nursing Coverage 24 Hours/Day were 4/1/25 through 4/30/25 and 5/1/25 through 5/31/25. A record review of the “Staffing Grid,” completed by Human Resources staff member Licensed Practical Nurse (LPN) #4, revealed the facility had RN and nursing coverage on all days in April and May 2025. A record review of the facility’s time sheets revealed the facility was not excessively low on staff on the weekends, had licensed nursing coverage 24 hours per day, and had eight (8) hours of Registered Nurse (RN) coverage daily. On 9/11/25 at 1:00 PM, during an interview, LPN #4 stated she was unaware the facility failed to electronically submit PBJ staffing data to CMS accurately for the third quarter of 2025. She confirmed she was responsible for creating the staffing schedule and stated that during April, May, and June 2025, salaried staff helped cover the schedule as needed. On 9/11/25 at 2:00 PM, during an interview, the Human Resources Coordinator stated the corporate office was responsible for submitting the PBJ staffing data for all the corporation’s facilities. She stated she was unaware the PBJ staffing information submitted for this facility was inaccurate until she was notified by the State Agency. On 9/11/25 at 3:30 PM, during an interview, the Administrator stated he was not aware the facility failed to electronically submit PBJ staffing data accurately during the third quarter of 2025. He stated the corporate office had been responsible for	F0851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0851 SS = F	Continued from page 19 submitting PBJ staffing data for all the corporation's facilities. The Administrator stated he understood the importance of accurately reporting PBJ information to CMS and acknowledged it was ultimately the facility's responsibility to ensure accuracy. He stated the facility changed ownership to a new company on 6/1/25, and the PBJ data errors occurred under the prior corporate ownership. The Administrator stated he believed a glitch in the prior corporation's system caused the PBJ data inaccuracies and confirmed the infractions occurred only in April and May 2025. He stated no PBJ infractions occurred after the new ownership assumed operations on 6/1/25.	F0851		
F0867 SS = E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F0867	1) Education was conducted with the Executive Director (ED) and the Interdisciplinary Team (IDT) on 09/11/2025 by the Regional Director of Clinical Services on the Quality Assurance and Performance Improvement (QAPI) Program. 2) All residents have the potential to be affected. 3) Education was provided to the ED and IDT on 09/11/2025 by the Regional Director of Clinical Services on Quality Assurance and Performance Improvement Plan. The QAPI Program is an ongoing comprehensive, data-driven Quality Assurance and Performance Program. The center's ED is accountable for the implementation and functioning. The program is a coordinated effort amongst departments and services with input from the Center Staff, residents and families. the QAPI meeting will be held at least monthly. QAPI Committee will follow up on Quality monitoring and observations for previous citations to ensure compliance of implemented procedures and monitor the interventions the committee put in place. New hires will be educated in orientation upon hire. 4) The ED will monitor the QAPI Program Quarterly beginning 09/15/2025 to ensure the program and implemented procedures and interventions are maintained. Findings will be reported to the QAPI Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	10/08/2025

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F0867 SS = E	Continued from page 20 systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement	F0867		

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F0867 SS = E	Continued from page 21 activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent the recurrence of previously cited deficiencies, specifically, the facility was cited for failing to accurately submit direct care staffing information and failed to ensure the QAPI program was sustained during transitions in leadership to maintain implemented procedures during an annual recertification survey on 4/18/24 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for two (2) of (11) deficiencies cited. F851 and F865/867. Findings Include: Review of the facility's policy, "Performance	F0867		

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F0867 SS = E	Continued from page 22 Improvement (QAPI)", dated 6/1/25, revealed, "…The Center and organization have an ongoing Performance Improvement Program with a design and scope that is ongoing and comprehensive…The design and scope of the program is to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement…Procedure: The Center Executive Director is accountable for the overall implementation…The Center identifies areas for continuous quality monitoring and the monitoring tools to be used…The Performance Improvement (QAPI) Committee reviews and coordinates the proposed activities and identifies the priorities for the coming year…Criteria for selecting aspects of care for improvement are based but not limited to…Regulatory – previous or current regulatory items or identified concerns…" Record review of the "Provider History Profile" revealed the facility received a citation for F851 – Payroll Based Journal and F865-QAPI Program/Plan. Record review of the Centers for Medicare and Medicaid Services (CMS)- 2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 4/18/24, revealed the facility received a citation for F851, "…Based on staff interview, record review, and facility policy review, the facility failed to accurately submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for Quarter 1 of Fiscal Year (FY) 2023 (October – December 2023) for one(1) of five (5) quarters reviewed.." and for F865, "…Based on staff interview, record review, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAI) Committee failed to ensure the program was sustained during transitions in leadership and failed to maintain implemented procedures and monitor the interventions the committee put into place in April 2022. This was for two (2) recited deficiencies originally cited in April 2022 on an annual recertification survey. The deficiencies were in the area of residents' rights and wounds. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of eight (8) deficient practice citations…" During the current recertification survey, the facility failed to accurately report staffing data to CMS using	F0867		

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F0867 SS = E	Continued from page 23 payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN) hours, and no licensed nursing coverage 24 hours/day and failed to sustain corrective actions to prevent recurrence of previously cited deficiencies. On 9/11/25 at 5:15 PM, during an interview with the Administrator, he explained that QAPI meetings are conducted quarterly, as well as on an as-needed basis when issues arise. He stated that staff report concerns to him or the Director of Nursing (DON), and he compiles the information for review during the QAPI meetings. He acknowledged that the repeat deficient practice related to Payroll-Based Journal (PBJ) reporting has continued. In his view, the issue is due to a processing glitch, explaining that when information is transmitted to CMS, he believes there may be an error within the Information Technology (IT) department that results in the discrepancies.	F0867		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	1) Root cause analysis was conducted by the Interdisciplinary Team. Contact Isolation signage for Resident #47 was placed on the door and Enhanced Barrier Precautions (EBP) was placed on the Resident #4's door. Education was provided by the Director of Nursing to the Nurse Practitioner (NP), Licensed Nurse #2 and Certified Nursing Assistant #4 on proper Personal Protective Equipment (PPE) requirements and Residents with wound should be on EBP and gowns are required. 2) Residents on isolation or EBP have the potential to be affected. 3) Education was provided by the Director of Nursing with all staff on EBP with emphasis on PPE and signage required for EBP and Contact Isolation. EBP will be used to reduce the spread of Multidrug-Resistant Organisms by using gloves and gowns for Resident with wounds. Signage indicating type of precautions will be implemented when a resident has a transmissible infection. Signage will be places on the door to inform staff of the type of precautions, instructions for use of PPE, and instructions to see the nurse before entering the room. New Hires will be educated in orientation upon hire. 4) Quality Monitoring will be conducted with a sample of 5 Residents with EBP or Isolation precautions 2	10/08/2025

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F0880 SS = D	Continued from page 24 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to prevent the possible spread of infection by not implementing	F0880	Continued from page 24 times a week for 4 weeks then weekly for 2 months beginning 09/15/2025 by the Infection Prevention Nurse or Unit Manager of the residents on EBP and Contact Isolation to ensure room doors have appropriate signage and to ensure staff are wearing appropriate PPE. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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F0880 SS = D	Continued from page 25 contact isolation precautions timely for (Resident #47) and enhanced barrier precautions (EBP) when providing care for (Resident #4) for two (2) of 22 sampled residents. Findings include: A review of the facility's "Policies and Practices - Infection Control," revised October 2018, revealed, "This facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. Policy Interpretation and Implementation…2. The objectives of the infection control policies and procedures are to: a. Prevent, detect, investigate, and control infections in the facility b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions…" A review of the facility's policy, "Enhanced Barrier Precautions," dated August 2022, revealed, "…Enhanced barrier precautions (EBPs) are used to prevent the spread of multidrug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation…2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. A. Gloves and gowns are applied prior to performing high-contact resident care activity…" Resident #47 On 9/8/25 at 10:00 AM, during an observation, there was no signage on doors on the 500 Hall indicating residents were on contact isolation precautions. Resident #47, who resides on the 500 Hall, was in her room, lying in bed with his eyes closed. There was no signage on the door indicating contact isolation precautions. On 9/9/25 at 9:08 AM, during an observation, there was signage on Resident #47's door as well as personal protective equipment (PPE) indicating the resident was on contact isolation. Red barrels with biohazard bags were also placed inside the resident's room. On 9/9/25 at 10:15 AM, during an interview, Registered	F0880		

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F0880 SS = D	Continued from page 26 Nurse (RN) #2 stated Resident #47 had tested positive in the hospital for COVID-19 and was admitted to the facility on 9/5/25. RN #2 stated she was not working on 9/5/25 and confirmed the facility failed to follow infection control protocol at the time of admission by not placing the resident on isolation precautions. RN #2 stated she normally ensured the contact isolation signage, PPE, and biohazard barrels were placed in the resident's room, and going forward, the admission nurse would assist in ensuring infection control protocols were followed when she was not working. RN #2 confirmed that failing to follow infection control protocol could cause the spread of infection to other residents and staff. A record review of the "Admission Record" revealed the facility admitted Resident #47 on 9/5/25 with diagnoses including COVID-19. A record review of the resident's Entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/25 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she had moderate cognitive impairment. A record review of the "Order Summary Report" revealed Resident #47 had a Physician's Order, dated 9/8/25, which was three (3) days after admission, for isolation related to a positive Covid-19 test. Resident #4 On 9/10/25 at 10:51 AM, during an observation of wound care provided by the Nurse Practitioner (NP), Licensed Practical Nurse (LPN) #2, and Certified Nursing Assistant (CNA) #4, the staff washed their hands and wore gloves, but failed to wear gowns. LPN #2 removed the old bandage on the resident's left hip, and the NP removed staples from the incision. There was no enhanced barrier precautions signage on Resident #4's door. On 9/10/25 at 10:59 AM, during an interview, LPN #2 and CNA #4 confirmed they failed to wear gowns while providing wound care. They stated they typically wore gowns when providing wound care and normally looked for signs on the door stating EBP. They confirmed there was not a sign on the door, and they did not think about wearing a gown at that time. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 8/20/25 with diagnoses including Left Femur Fracture.	F0880		

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F0880 SS = D	Continued from page 27 A record review of the Admission MDS, with an ARD of 8/27/25, revealed Resident #4 had a BIMS score of 13, which indicated he was cognitively intact. A record review of the “Order Summary Report” revealed Resident #4 had a Physician’s order, dated 8/21/25 for Enhanced Barrier Precautions related to wounds. On 9/10/25 at 11:17 AM, during an interview, the Director of Nursing (DON) stated staff should wear gowns and gloves when removing staples from an incision or providing wound care. The DON stated EBP required the use of gowns and gloves during wound care, and an EBP sign should have been placed on Resident #4’s door. The DON also stated a contact isolation sign and PPE should have been placed on Resident #47’s door. On 9/11/25 at 1:10 PM, during an interview, RN #2 stated an EBP sign, and PPE should have been placed on Resident #4’s door when the resident was admitted. RN #2 stated the facility failed to place the sign and PPE on the door because she was not working that day. She stated she was unaware that the sign and PPE were missing. RN #2 stated staff could spread infection by not wearing gowns while providing wound care and that it was facility protocol to follow Enhanced Barrier Precautions. On 9/11/25 at 2:20 PM, during an interview, the Administrator stated he expected the facility to follow contact isolation and EBP policies when providing care.	F0880		