STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	**1530 BROAD AVE , GULFPORT, Mississippi, 39501**

(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 a Complaint Investigation (CI), MS #2996239 at the facility from 05/11/2026 through 05/12/2026. CI MS #2996239 was investigated related to accidents. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F657 and F689. The facility held a license for 180 beds with a census of 130.	F0000		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F0657		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0657 SS = E	Continued from page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to revise care plans to reflect resident falls and interventions implemented to prevent recurrence for two (2) of three (3) residents reviewed for falls. Resident #1 and Resident #2. Findings include: A review of the facility's policy, "Comprehensive Care Plans," revised 11/14/25, revealed, "… It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality…" A review of the facility's policy, "Fall Prevention Program," revised 11/7/25, revealed "…Each resident's risk factors and environment hazards will be evaluated when developing the resident's comprehensive care plan. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed… When any resident experiences a fall, the facility will … f. Review the resident's care plan and update …" Resident #1 A record review of Resident #1's "Care Plan Report" revealed an individual care plan with focus "Is At Risk for Injury such as falls, fractures, skin tears, and bruises r/t (related to) unsteady gait, Dementia, fragile skill at risk for falls r/t history of falls, left side hemiplegia" dated initiated 12/23/25. The goal revealed Resident #1 "will remain free from injury/falls, thru next review" with a last revision date of 3/4/26. Four (4) "Interventions/Tasks" were listed with the last revision date of 2/28/26. There was no new intervention added following the fall on 4/7/26. A record review of Resident #1's "Fall" documentation, dated 4/7/26 at 1:42 AM, revealed "… Incident location: Resident's room … Resident was observed sliding out of bed onto the floor mat at approximately 1:42 AM. No signs or symptoms of	F0657		

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F0657 SS = E	Continued from page 2 injury noted at this time. Full body audit completed with no abnormalities observed … MD (medical doctor) was notified with no new orders received. Attempted to notify responsible party multiple times; however, contact was unsuccessful. Resident assisted back to bed safely …" A record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/22/25, with a re-entry on 3/20/25 and diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/23/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident's cognition was severely impaired. Resident #2 A record review of Resident #2's "Care Plan Report" revealed an individual care plan with focus "At Risk for falls r/t impaired balance, muscle weakness/atrophy" dated initiated 2/16/26 and revised on 2/20/26. The goal revealed Resident #2 "will remain free from injury/falls, thru next review" with the last revision on 3/2/26. There were three (3) "Interventions/Tasks" initiated 2/19/26 with no new intervention added following the fall on 4/2/26. A record review of the "Fall" documentation, dated 4/2/26 at 7:47 PM, revealed, "… Incident location: Resident's room … 75-year-old female resident was found on the floor lying on her left side. Upon assessment, resident was alert and stated that she slid out of her chair onto the floor after returning from bathroom …" A record review of the "Admission Record" revealed the facility admitted Resident #2 on 2/13/26 with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Digestive System. A record review of the 5-Day Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/26 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired. On 5/12/26 at 10:45 AM, during an interview with Licensed Practical Nurse (LPN) #2, she reported she completes care plans. She reported care plans for falls were not accurate and were not revised	F0657		

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F0657 SS = E	Continued from page 3 following each fall. She stated that when the incident or fall report does not mention any new intervention, there is nothing for her to care plan. She reported she was aware a new intervention should be put into place after each fall to prevent further falls. She stated the former Director of Nursing (DON) did not hold daily morning clinical meetings, and the MDS department was not informed of falls or interventions. She stated interventions are a team effort and reported morning meetings were now being conducted since the interim DON had been in place, and care plans had been updated more regularly. LPN #2 reviewed Resident #1 and Resident #2's care plans and confirmed the care plans were not revised with new interventions following the residents' falls that occurred in April. On 5/12/26 at 1:30 PM, during an interview with the DON, she reported she was aware care plans should be revised to include new interventions to prevent further falls. She explained since becoming interim DON, she had started conducting daily clinical meetings, and the staff were trying to work together on incident reports, falls, new interventions, and revising or updating care plans. She stated she expected the team to work together to determine new interventions after each fall to prevent further falls. She confirmed after review that no new interventions were implemented following the last falls for Resident #1 and Resident #2. She stated she expected care plans to reflect the current plan of care on a daily basis. On 5/12/26 at 1:45 PM, during an interview with the Administrator, he explained he was aware care plans were expected to be revised to include new interventions after each fall to prevent additional falls. He stated he expected staff to update the care plans daily for accuracy.	F0657		
F0689 SS = E	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.	F0689		

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F0689 SS = E	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to analyze falls and implement interventions to reduce the risk for recurrence for two (2) of three (3) residents reviewed for falls. Resident #1 and Resident #2. Findings include: A review of the facility's policy, "Fall Prevention Program," revised 11/7/25, revealed "… Each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls … Policy Explanation and Compliance Guidelines: … 9. When any resident experiences a fall, the facility will … f. Review the resident's care plan and update … g. Document all assessments and actions…" Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/22/25, with a re-entry on 3/20/25 and had diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/23/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident's cognition was severely impaired. A record review of Resident #1's "Fall" documentation, dated 4/7/26 at 1:42 AM, revealed "… Incident location: Resident's room … Resident was observed sliding out of bed onto the floor mat at approximately 1:42 AM. No signs or symptoms of injury noted at this time. Full body audit completed with no abnormalities observed … MD (medical doctor) was notified with no new orders received. Attempted to notify responsible party multiple times; however, contact was unsuccessful. Resident assisted back to bed safely …" There was no documentation indicating the identification of measures to reduce the hazards or risks, no root cause for the fall was identified, and no intervention was developed to prevent recurrence. On 5/11/26 at 3:40 PM, during an interview and observation of Resident #1, the resident's room door was closed. Resident #1 was observed lying in bed on her right side asleep with eyes closed. The bed was in a low position. Fall mats were noted on both	F0689		

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F0689 SS = E	Continued from page 5 sides of the bed. One-half side rails were observed up times two (x2), and pillows were noted to each side of Resident #1. During an interview, Resident #1's daughter, who was the resident's Resident Representative (RR), voiced complaints about her mother falling and stated she felt nothing was done or explained to her about the falls. She stated she felt as if the Director of Nursing (DON) ignored her requests for information and would tell her the falls were under investigation. She stated she was not aware of any new interventions put into place since Resident #1 had experienced falls. Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 2/13/26 with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Digestive System. A record review of the 5-Day Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/26 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired. A record review of the "Fall" documentation, dated 4/2/26 at 7:47 PM, revealed, "… Incident location: Resident's room … 75-year-old female resident was found on the floor lying on her left side. Upon assessment, resident was alert and stated that she slid out of her chair onto the floor after returning from bathroom …" There was no documentation indicating the identification of measures to reduce the hazards or risks, no root cause for the fall was identified, and no intervention was developed to prevent recurrence. On 5/11/26 at 5:00 PM, during an interview with Registered Nurse (RN) #1, he reported when a resident has a fall, whoever finds the resident will notify the nurse, and the nurse will assess the resident and notify the family and physician. On 5/12/26 at 9:05 AM, during an observation and interview with Resident #2, she reported she had been at the facility about (2) months. She reported she had experienced one (1) fall since being admitted to the facility but was doing better now. On 5/12/26 at 10:45 AM, during an interview with Licensed Practical Nurse (LPN) #2, she reported she was aware a new intervention should be implemented after each fall to prevent further falls. She reported the former DON did not hold daily	F0689		

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F0689 SS = E	Continued from page 6 morning clinical meetings, and the MDS department was not informed of falls or interventions. She stated interventions are a team effort and reported morning meetings were now being conducted since the interim DON had been in place. On 5/12/26 at 1:30 PM, during an interview with the DON, she reported she was aware a new intervention must be put into place to prevent further falls. She explained since becoming interim DON, she had started conducting daily clinical meetings, and the staff were trying to work together on incident reports, falls, and new interventions. She stated she expected the team to work together to determine new interventions after each fall to prevent further falls. She confirmed after reviewing the fall documentation that no new interventions were put into place following the falls for Resident #1 on 4/7/26 and Resident #2 on 4/2/26. On 5/12/26 at 1:45 PM, during an interview with the Administrator, he explained he was aware fall and incident reports were expected to include new interventions after each fall to prevent additional falls. He stated he expected staff and the interdisciplinary team to follow regulations and implement new interventions after each fall.	F0689		