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	255092	A. BUILDING _____ B. WING _____	C 04/19/2022

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) for MS #18699, MS #18632, MS #18707, and MS #18714 at the facility from 4/11/22 through 4/19/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated MS# 18699 for not reporting allegations of abuse to the proper authorities and outside agencies but did not substantiate allegations of sexual and physical abuse, residents not having access to water, and pests. The SA cited F609 related to MS #18699. The SA substantiated MS #18707 for a resident's room not being clean and for not providing adequate grooming for a dependent resident. The SA cited F584, and F676 related to MS #18707. The SA did not substantiate MS # 18632 and MS #18714 for resident neglect, physical environment, and verbal abuse of a resident. The facility held a license for 180 beds, with a census of 108.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		6/2/22

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

Electronically Signed | 05/12/2022

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F 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide a clean homelike environment as evidenced by visible dirt and stains to the flooring, bed frame, and side rails, baseboard not adhered to the wall and disrepair of a bedside table for one (1) of seven (7) resident rooms observed. Resident #5.	F 584	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by the provisions of State and Federal laws.	

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F 584	Continued From page 2 Findings include: Record review of the facility's "Policies and Procedures" with the "Subject" of "Maintenance" and an "Effective Date" of 11/30/14 revealed, "Policy The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Procedure The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition..." Record review of the facility policy titled "Cleaning and Disinfection of Environmental Surfaces" dated August 2019 revealed, "Policy Interpretation and Implementation...9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.". Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled..." On 4/13/22 at 9:00 AM, during a telephone interview with Resident #5's daughter, she stated she had visited her father and was very concerned about the condition of his room. She described the floor of the room as dirty and stained and the bed as dirty and rusty. On 4/13/22 at 10:15 AM, the State Agency (SA) observed the floor under the sink in the Resident	F 584	*On April 15, 2022, Resident #5 was assessed by Director of Nursing, no adverse findings noted. On April 15, 2022, Resident#5 floor was cleaned to include the area under the sink, behind the door to the edge of the bathroom door by Housekeeper. On April 20, 2022, Resident #5 baseboard was cleaned, repaired and attached to the wall by Maintenance Director. On April 20, 2022, Resident #5 bed was replaced with a bed with no rust colored substance and bedside table was removed and replaced by Maintenance Director. * All residents have the potential to be affected * All resident beds were checked for rust colored substance on them beginning April 21, 2022 through April 25, 2022 by Administrator and Weekend Registered Nurse Supervisor. Thirty-seven (37) of one-hundred and forty (140) beds had rust colored substance on them or needed cleaning. The thirty-seven (37) beds were cleaned, sanded and painted to remove rust colored substance by Maintenance Department Beginning April 27, 2022 through May 17, 2022. All resident room were checked for cleanliness of flooring, beginning April 15, 2022 through April 21, 2022 by Administrator and Weekend Registered	

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F 584	Continued From page 3 #5's room had the appearance of being discolored and stained for approximately two (2) inches from the wall outward for two (2) feet along the wall; the brown substance on the floor did not wipe away with a dry paper towel, but did wipe away with a damp paper towel. There were dark brown and black stains on the floor which ran the distance of approximately six (6) feet from behind the door to the edge of the bathroom door and the stains could not be wiped away with dry or damp paper towel. The baseboard behind the headboard of the resident's bed was visibly pulled away from the wall approximately 7/8 of an inch to one inch with what appeared to be dirt, dust, and bits of white paper in the crack between the baseboard and wall. Resident #5's bed frame and side rails on both sides of the bed had the appearance of being dusty and had a coarse, abrasive, rust colored substance on both rails. The bedside table had a missing front top drawer and the bottom drawer had a broken handle. On 4/13/22 at 1:26 PM, during an observation in Resident #5's room and interview with the Laundry and Housekeeping Supervisor (LHS) she identified the discoloration on the floor under the sink as "dirt" and confirmed that it needed to be cleaned. She explained the dark brown and black stains on the floor which ran from behind the door to the edge of the bathroom door would require the attention of the maintenance department. She had previously reported to the maintenance department that the baseboard was not adhered to the wall, but she was unsure if it had been repaired and came loose again, or if it had not been repaired at all. She thought she had reported the broken bedside table to maintenance and she expressed that she considers the resident's bed, overbed table, and bedside table	F 584	Nurse Supervisor. Thirty-seven (37) of ninety-six rooms required floor care. Thirty-seven rooms were moped and cleaned to remove stains by Housekeeping Services and completed on April 27, 2022. Housekeeping staff were inserviced by Administrator and / or Weekend Registered Nurse Supervisor beginning on April 15, 2022 ending on April 25, 2022 on facility policies, "General Hospitality Services, 7-Steps Daily Room Cleaning, Complete Room Cleaning and Cleaning and Disinfection of Environmental Services." Facility staff was inserviced on facility policy "Maintenance" by Registered Nurse to include location of Maintenance Repair Binder that is located on each unit beginning April 15, 2022 and ending on April 25, 2022. * Housekeeping Supervisor and / or Maintenance will monitor cleanliness of resident rooms, baseboards properly attached to walls, bed for rust colored substance and furniture needing repair ten (10) rooms weekly times three weeks, then monthly times three months. Monitoring began May 10, 2022. Findings from monitoring of cleanliness of resident rooms, baseboard properly attached to walls, bed for rust colored substance and furniture needing repair will be brought to the Quality Assurance Performance Improvement Committee Meeting by Maintenance Director quarterly to	

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F 584	Continued From page 4 as "equipment" which is maintained by the maintenance department. She commented that the substance on the bed frame "looks like dust and rust, that's rust" and the substance on both of the side rails "looks like rust and some dirt, they need to be cleaned and painted, or replaced". On 4/13/22 at 1:37 PM, during an observation in Resident #5's room and an interview with the Director of Environmental Services, he said the dark brown and black stains on the floor which ran from behind the door to the edge of the bathroom door would require a metal scrapper to remove. He thought this area was caused by cleaning the hallway floor and the water entering the room under the door and mixing with dirt on the floor. He commented that the baseboard was probably pulled away from the wall by the bed and confirmed the crack between the baseboard and wall had gathered some dirt and paper and it needed to be cleaned and glued back to the wall. He acknowledged the coarse rust colored substance on the bed frame and side rails was "rust" and stated "it needs to be painted, cleaned, wiped off and painted, it has a little rust on it.". He will also repair the bedside table drawers or find the resident another one to use. On 4/13/22 at 3:00 PM, an interview with the Administrator revealed the facility used a computer program for scheduling preventative maintenance and repairing equipment. She confirmed that the facility policies, when followed, provided for the maintenance of equipment and the cleaning and disinfection of environmental surfaces. Record review of the "Admission Record" for Resident #5 revealed he was initially admitted by	F 584	determine the effectiveness and make necessary changes as indicated. ADHOC Quality Assurance Committee Meeting was held on April 28, 2022.	

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F 584	Continued From page 5 the facility on 6/03/11 with a most recent admission date of 7/17/2020. He had diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia, and Dysphagia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/07/22 for Resident #5 revealed he required a staff assessment for mental status and he was severely cognitively impaired.	F 584		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		6/2/22

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F 609	Continued From page 6 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to report an allegation of abuse for two (2) of three (3) residents reviewed for abuse. Resident #1 and Resident #2. Findings include: Record review of the facility's policy titled "Abuse, Neglect, Exploitation & Misappropriation", with an effective date of 11/28/2017, revealed "Any employee, who witnesses or has knowledge of an act of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, 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 or result in serious bodily injury ...to the Administrator and to other officials in accordance with State law ...Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations ..." A record review of a complaint received by the State Agency (SA) from the Attorney General's office, MS #18699, revealed NA #1 alleged the facility had not reported allegations of sexual abuse against Resident #1 and Resident #2.	F 609	* Resident #1 was reassessed on April 1, 2022 and Resident #2 was assessed April 1, 2022, by Director of Nursing with no adverse findings noted. ON April 20, 2022 Resident #1 and Resident #2 were reassessed by Director of Nursing. On April 22, 2022, Administrator reported to the State Agency allegation of abuse for Resident #1 and Resident #2. * All residents have the potential to be affected. *Facility Administrator and Director of Nursing was inserviced on facility policy, "Abuse, Neglect and Misappropriation to include reporting on April 13, 2022 by Regional Director of Clinical Services. Registered Nurse inserviced facility staff on Abuse, Exploitation and Misappropriation to include reporting timely beginning April 15, 2022 through April 25, 2022. On April 14, 2022, Administrator reviewed resident grievance for the previous six (6) months for reporting. All grievances had been addressed appropriately. Courtesy rounds were made with residents with Brief Interview Mental Status (BIMS) score of 12 or above to determine any potential for abuse, neglect or misappropriation concerns by	

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F 609	Continued From page 7 Resident #1 Record review of the "Admission Record" for Resident #1 revealed the facility initially admitted the resident on 3/6/19, with a most recent admission date of 3/14/2019. She had diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Hypertension, and Chronic Obstructive Pulmonary Disease. Record review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/22, revealed she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. An interview on 4/11/22 at 5:15 PM with Nurse Aide (NA) #1 revealed NA #2 told her that she (NA #2) had witnessed Certified Nursing Assistant (CNA) #1 touching Resident #1 in an inappropriate manner through the open door of the resident's room. NA #1 stated she did not report what NA #2 told her to the Director of Nursing or the Administrator, but she reported it to the Attorney General's (AGs) office on 4/6/22. An interview on 4/12/22 at 8:30 AM with Licensed Practical Nurse (LPN) #1 revealed she was notified on 3/15/22 by NA #2 that she (NA #2) had seen CNA #1 touching Resident #1 inappropriately on 3/10/22, which was five (5) days after NA #2 reportedly observed the alleged abuse. LPN #1 then reported the allegation to the Unit Manager, Registered Nurse (RN) #1, immediately after NA #2 reported it to her.	F 609	Administrator beginning April 20, 2022 and ending May 12, 2022. Future allegation of Abuse, Neglect, Misappropriation will be reported to State Agency according State and Federal Regulations. * Administrator will monitor grievance log once weekly times three weeks, then monthly times three months for timely reporting to State Agency. Rounds will be made to interview cognitive residents with a Brief Interview Mental Status (BIMS) greater than 12 to determine if any suspicion of abuse has occurred weekly times three weeks, then monthly times three months. Monitoring began April 20, 2022. Findings will be brought to the Quality Assurance Performance Improvement Committee by Administrator monthly for three months then quarterly to determine effectiveness and make necessary changes as indicated. ADHOC Quality Assurance Committee Meeting was held on April 28, 2022.	

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F 609	Continued From page 8	F 609		

An interview on 4/12/22 at 1:50 PM, with the Risk Manager, Registered Nurse (RN) #2, she stated she had not participated in or been notified of any allegation made regarding Resident #1 and CNA #1. She stated the proper procedure was for the DON or Administrator to notify her immediately about any allegations and allegations should be reported to the SA. She confirmed she did not have the opportunity to report the allegation because she was not notified of the allegation.

An interview on 4/12/22 at 2:25 PM with the Director of Nursing (DON) revealed on 3/15/22 at approximately 11:00 PM, she received a phone call from RN #1 who reported LPN #1 had been told by NA #2 she had witnessed CNA #1 touching Resident #1 in an inappropriate, sexual way on 3/10/22. The DON confirmed the facility did not report the allegation of abuse related to Resident #1 to the SA. The DON confirmed the facility policy was that allegations of abuse were to be reported immediately and were to be reported to the SA.

An interview on 4/12/22 at 2:45 PM with RN #1 confirmed she was notified by LPN #1 of an allegation of abuse, but she was not sure of the exact date. RN #1 explained that as soon as she was told of the allegation, she called the Administrator and the DON.

Resident #2

Record review of the "Admission Record" for Resident #2 revealed the facility originally admitted him on 8/27/15, and he had a most recent admission date of 1/2/2020. He had diagnoses including End Stage Renal Disease and Diabetes Mellitus.

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F 609	Continued From page 9	F 609		

Record review of the Quarterly MDS with an ARD of 3/01/22 revealed he had a BIMS score of 14 which indicated he was cognitively intact.

An interview on 4/11/22 at 5:15 PM with Nurse Aide (NA) #1 confirmed she called the AG's office Resident #2 told her CNA #1 touched him in a way he didn't like when CNA #1 was providing care. NA #1 said she reported the allegation regarding Resident #2 to the DON, but she could not recall the date.

An interview on 4/12/22 at 1:50 PM with the Risk Manager, RN #2, confirmed she had not been notified of any allegation made involving Resident #2 and CNA #1. She stated she did not report the allegation because she was not notified of the allegation.

An interview on 4/12/22 at 2:25 PM with the DON revealed she was informed by NA #1 that Resident #2 had made a comment about CNA #1 touching him in a way he didn't like while she was investigating another allegation against CNA #1. The DON confirmed the facility did not report the allegation to the SA.

An interview on 4/12/22 at 3:15 PM with the Administrator confirmed the allegations of abuse of Resident #1 and Resident #2 were not reported to the SA. She indicated that she had not reported the allegations because the facility's investigation had shown that Resident #1 and Resident #2 both denied the abuse and there was no other proof to substantiate the allegations. She had not involved the Risk Manager because she was new and already had other investigations she was working on.

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F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		6/2/22

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F 676	Continued From page 11 by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for dependent residents, including nail care and hair care for two (2) of seven (7) sampled residents Resident #5 and Resident #7. Findings Include: Record review of the facility's "Policies and Procedures" with the "Subject" of "Grooming Activities" with an "Effective Date of 11/30/2014 revealed, "Policy: Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. Procedure: 1. Grooming activities shall be offered daily. 2. Grooming Activities shall include, but are not limited to...Combing Hair...Nail Care" Resident #5 On 4/13/22 at 9:00 AM, in an interview with Resident #5's daughter, she voiced dissatisfaction with the grooming and stated when she visited, he had long, jagged fingernails. On 4/13/22 at 10:15 AM, the State Agency (SA) observed Resident #5 in his room and noted the resident's fingernails were long and ragged (not smooth). On 4/13/22 at 11:30 AM, in an interview with the Responsible Representative (RR) for Resident #5 she stated she was aware the resident's fingernails "need trimming". She stated, "I have asked them (staff) to trim his fingernails a couple of times in the last couple of weeks, but they haven't done it yet". She stated she was	F 676	* On April 20, 2022, Resident #5 nails were trimmed and filed by Registered Nurse. On April 20, 2022, Resident #7 agreed to have hair trimmed to remove matted hair and washed by Certified Nursing Assistant. * All resident have the potential to be affected *All residents were observed for need of nail care and hair care on April 20, 2022 by Registered Nurse Unit Manager and Assistant Director of Nursing Services. Seven (7) residents had their nails trimmed and filed on April 20, 2022 by Registered Nurse Unit Manager and Assistant Director of Nursing. Beginning April 15, 2022 through April 25, 2022 Registered Nurse inserviced Certified Nursing Assistants on facility policy, "Care of Nails and Grooming Activities, Following Care Plan" to include providing ADL care. * Registered Nurse Unit Manager, Assistance Director of Nursing Service will monitor hair and nails of residents twice a week times three (3) weeks, then monthly times three months. Monitoring began April 29, 2022. Findings from weekly hair care and nail care monitoring will be brought to the Quality Assurance Performance Improvement Committee by Director of Clinical Services monthly and then quarterly to determine effectiveness	

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	255092	A. BUILDING _____ B. WING _____	C 04/19/2022

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F 676	Continued From page 12 concerned the resident would scratch his skin because his fingernails were long and jagged. She reported she could not recall the names of staff she had asked about trimming the resident's fingernails. Record review of the "Admission Record" for Resident #5 revealed he was initially admitted by the facility on 6/03/11 with a most recent admission date of 7/17/2020. He had diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia, and Dysphagia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/07/22 for Resident #5 revealed he required a staff assessment for mental status and he was severely cognitively impaired. He was dependent upon staff for personal hygiene. Resident #7 On 4/13/22 at 11:00 AM, in an observation and interview with Resident #7, the SA noted her hair was extremely matted in the back, to the point that her hair was sticking up behind her head as her head rested on the pillow. When she lifted her head, her hair remained in place. Resident #7 stated her hair could not be brushed or combed because "it's matted too bad; the brush or comb won't go through it". She reported that the staff had told her that her hair was too matted for them to do anything with it except cut out the matted part. She stated, "I hate to have to get all my hair cut off". On 4/13/22 at 11:10 AM, in an interview with the son of Resident #7, he expressed dissatisfaction with the way his mother's hair looked. He	F 676	and make necessary changes as indicated. ADHOC Quality Assurance Committee Meeting was held on April 28, 2022.	

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F 676	Continued From page 13	F 676		

questioned how the facility had let her hair get so bad and how long had it been since her hair had been brushed.

On 4/13/22 at 11:20 AM, in an interview with CNA #5, she stated Resident #7 used to be able to do more for herself and she took pride in her appearance. She used to be able to brush her own hair back then. CNA #5 confirmed the resident's hair was "very matted" and stated, "you can't comb it now, it's too matted".

Record review of the "Admission Record" for Resident #7 revealed Resident #7 was admitted by the facility on 6/8/20 with diagnoses including Chronic Obstructive Pulmonary Disease and Pulmonary Fibrosis.

Record review of Resident #7's Quarterly MDS with an ARD of 3/16/22 revealed she had a Brief Interview for Mental Status (BIMS) score of 12, which indicated she had moderate cognitive impairment. She also required extensive one-person assistance for personal hygiene.

On 4/13/22 at 3:39 PM, during an interview with Registered Nurse (RN) #4, he stated that he acted as the RN Supervisor on a weekly basis and he generally takes care of the nail clipping. He had not noted the condition of the hair of Resident #7 or the condition of the fingernails of Resident #5 and no one had reported to him that there was a problem with the hair of Resident #7 or that Resident #5 needed nail care.

On 4/18/22 at 3:00 PM, in an interview with the Director of Nurses (DON), she stated CNAs were responsible for ADL care for residents, including but not limited to hair care and fingernail care.

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F 676	Continued From page 14 She stated that if there were some reason the CNAs could not complete ADL care, the CNA should notify the nurse assigned to the resident or to the Assistant Director of Nursing (ADON) or Nurse Supervisor for the hall. She stated that she was aware of the condition of Resident #5's hair and confirmed the resident's hair was matted. She stated that the staff were not able to brush or comb the "tangled part" and that Resident #5 had not consented to have the "matted part" cut out. She confirmed the facility was responsible for providing ADL care according to the facility policy. She stated any staff could use the facilities of the facility beauty shop to care for resident hair needs, or the residents' hair could be cared for in the shower. She stated she did not know how the condition of Resident #7's hair became so matted and she was not aware of the length or jagged condition of Resident #5's fingernails.	F 676		