STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a Complaint Investigation CI MS# 19081, at the facility from 06/27/22 to 06/30/22. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate CI MS# 19081 for Abuse, Resident Rights and poor Quality of Care due to a lack of sufficient evidence. and there were no citations related to the complaint. The SA cited F637, F655, F656, F686, and F812 during the survey. The facility held a licence for 73 beds, with a census of 49.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment (SCSA) for a resident	F 637	A significant change in status assessment was completed on Resident #45 on 6/08/2022 by the Minimum Data Set Coordinator.	8/12/22

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

Electronically Signed | 07/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 1 admitted to hospice services for one (1) of one (1) resident reviewed for hospice services. (Resident #45) Findings include: A record review of a letter provided by the Administrator revealed, "It is the policy of this facility to follow the Resident Assessment Instrument (RAI) Manual for MDS transmission purposes." A record review of the RAI Manual Version 3.0 revealed ... "Significant Change in Status Assessment ... must be completed within 14 days after the determination that the criteria are met for a Significant Change in Status Assessment." ... "If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment." On 06/28/2022 at 9:30 AM, during a phone interview with Resident #45's daughter, she explained her mother was admitted to hospice services on 04/04/2022. Record review of Resident #45's "Order Review History Report" dated 05/30/2022 through 06/30/2022 revealed a Physician's Order dated 04/04/2022 to "Admit to (Proper Name of Hospice Provider)." Record review of Resident's #45's MDS assessments revealed there was no SCSA completed within 14 days after she elected the hospice benefit on 04/04/2022. The MDS SCSA with an Assessment Reference Date (ARD) of 06/08/2022 was more than two (2) months after	F 637	All residents receiving hospice have the potential to be affected by this deficient practice. The Administrator completed an in-service with the Minimum Data Set Coordinator (MDS) on 7/18/2022. The in-service between Administrator and Minimum Data Set Coordinator covered RAI guidelines, and facility policy for care planning and assessment completion periods, specifically base line care planning, significant changes, comprehensive care plans, re-admit, and new admissions policy. The Director of Nursing completed an audit for all residents receiving hospice care on 7/18/2022, with no negative findings. The MDS nurse will audit records of all residents receiving hospice care weekly x four (4) weeks starting on 7/18/2022 ending 8/8/2022 then monthly x three (3) months starting on 9/1/2022 ending 11/1/2022, document findings and take corrective action as needed. MDS nurse will report finding from weekly and monthly audits to the Quality Assurance Performance Improvement Committee at the monthly meeting starting on 8/4/2022 ending on 11/4/2022, for review, revision, and resolution of plan as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 2	F 637		

her admission to hospice services.

On 06/28/2022 at 1:45 PM, during an interview with Social Worker #1/Hospice Coordinator, she explained Resident #45 is currently on hospice services

On 06/29/2022 at 8:00 AM, during an interview with Registered Nurse (RN) #1, Hospice Nurse, she confirmed Resident #45 has been on hospice services since 04/04/2022 and she visits the resident weekly.

On 06/30/2022 at 01:30 PM, during an interview with Licensed Practical Nurse (LPN) #2, MDS nurse, she explained a MDS SCSA should be completed within seven days of the resident's change in condition. She confirmed Resident #45 was admitted to hospice services 04/04/2022 and the significant change was just missed. The day the resident went on hospice services should have been the ARD of the SCSA. She uses the RAI manual as a reference when completing MDS assessments.

On 06/30/2022 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained a SCSA MDS should be completed when a resident has had a change in condition and the change is recognized. Her expectation of the MDS nurse is to complete the assessments to reflect when a resident has had a significant change. She confirmed Resident #45 was admitted to hospice services on 04/04/2022 and the Significant Change MDS was not completed until 06/08/2022.

On 6/30/2022 at 2:20 PM, during an interview with the Administrator, he explained his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 3 expectations of the MDS nurse is to complete the assessments when they are due. A record review of Resident #45's "Admission Record" revealed the facility initially admitted her on 10/24/2019 and she has a most recent admission date of 02/23/2022 with diagnoses including Dementia Chronic Obstructive Pulmonary Disease (COPD), Anemia, and Rheumatoid Arthritis.	F 637		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure a baseline care plan included nursing healthcare information necessary to properly care for a newly admitted resident for one (1) of (18) sampled residents. Resident #250. Findings Include: Review of the facility's policy "Care Plan -Baseline" dated June 1, 2000, revealed "Policy Statement It is the policy of this facility that an individualized baseline care plan be developed within 48 hours of admission that includes instructions needed to provide effective person center care of the resident that meets professional standards of quality care, maintained and/or updated, while a comprehensive care plan is developed ..."	F 655	The Minimum Data Set Nurse completed a comprehensive care plan for Resident #250 on 6/20/2022. All residents have the potential to be affected by this deficient practice. All members of the interdisciplinary team were in-serviced by the Administrator on completion of the baseline care plans on 7/18/2022. The Director of Nursing completed an audit on residents admitted as of 7/1/2022 to ensure baseline care plans were completed on 7/18/2022 with no negative findings. The Administrator will audit new admissions weekly for timely completion of the baseline care plans four (4) times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 5 Record review of Resident #250's "(Proper Name of Corporation) Baseline Careplan-V3 (Version 3)" with an effective date of 06/07/2022 and admission date of 06/07/2022 revealed the "Nursing" section of the individualized baseline care plan was not completed and did not provide instructions needed to provide effective person-centered care of the resident. Record review of the clinical record revealed there were no nursing comprehensive care plans completed for Resident #250. On 06/29/22 at 01:35 PM, in an interview with Licensed Practical Nurse (LPN) #2 who is the Minimum Data Set (MDS) and Care Plan Nurse, she confirmed the nursing section of the baseline care plan was not completed. On 06/30/22 at 10:15 AM, the State Agency (SA) conducted an interview with LPN #2. She stated that each person individually has a section of the baseline care plan that they are responsible for completing. The floor nurse who completes the resident admission is responsible for initiating and completing the nursing section of the baseline care plan. She verified that she is ultimately responsible for making sure that baseline care plans and comprehensive care plans are completed. The care team evaluates the resident's situation, and the baseline and comprehensive care plan gives a better approach to take care of the resident. On 06/30/22 at 10:50 AM, the SA conducted an interview with the Director of Nursing (DON). During the interview, she confirmed the admitting nurse is responsible for initiating and completing the baseline care plan for a new resident. The	F 655	weeks beginning 7/22/2022 ending 8/19/2022 then monthly x two (2) months starting 9/1/2022 ending 11/1/2022 document findings and take corrective action as needed. The Administrator will report findings of weekly and monthly audits for completion of baseline care plans to the Quality Assurance Performance Improvement Committee monthly x four (4) months beginning 8/4/2022 and ending 11/1/2022 for review, revision, and/or resolution of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 6 MDS nurse is responsible for ensuring the baseline care plan is completed. She stated baseline care plans and comprehensive care plans are needed so that the staff will know how to meet the resident's specific needs. On 06/30/22 at 11:38 AM, the SA conducted an interview with the Administrator. He stated that the MDS Nurse is responsible for baseline and comprehensive care plans and that care plans give the staff a picture of how to treat each newly admitted resident. He commented that "It would be a struggle to give the proper care" without a baseline or comprehensive care plan. Record review of the Resident #250's "Admission Record" revealed the facility admitted her on 06/07/22 and she had diagnoses including Metabolic Encephalopathy and Unspecified Diastolic (Congestive) heart failure.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review the facility failed to develop a comprehensive care plan for three (3) of 18 residents reviewed for care plans. (Resident # 4, Resident #35, Resident #39) Findings Include: Review of the facility's policy, "Care Plan Committee/Team" dated 6/1/2000, revealed, "Policy Statement It is the policy of this facility that the Care Planning Committee/Team develops a	F 656	The Minimum Data Set Nurse (MDS) completed a pressure ulcer care plan for Resident #4 on 6/28/2022. Minimum Data Set Nurse revised care plan for Resident #35 on 7/01/2022 to include use of anticoagulant, COPD, Hypertension, and Diabetes Mellitus. The Comprehensive care plan was revised for Resident # 39 on 7/19/2022 to include Primary Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease by the Minimum Data Set Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 comprehensive, person-centered care plan for each resident within seven (7) days of completing the resident assessment (MDS) (Minimum Data Set). Care Plan to be completed no later than 21 days after admission ...Procedures ...3. Care Plan will be modified as needed to reflect residents current status and needs ..." Resident #4 Record review of Resident #4's "Progress Notes" with the "Type" listed as "Admission Summary" dated 6/20/22 at 17:16 (5:16 PM), revealed, "Patient admitted from (Proper Name of Local Hospital) ...stage III (Stage 3) sacral wound with wet to dry dressing CDI (Clean, Dry, Intact) ..." Record review of Resident #4's "Progress Notes" with the "Type" listed as "PAR (Problem-Action-Results)", dated 6/28/22 at 14:40 (2:40 PM), revealed, "PAR RT (Related To) Wounds: Resident readmitted from hospital 6/20/22 with noted unstageable wound to R (Right) heel. Also has Stage 3 to sacrum which is reopened area. Also noted with unstageable to L (Left) heel ..." Record review of the Resident #4's comprehensive care plans revealed there was no pressure ulcer care plan developed to reflect the resident's current status and needs upon his readmission from the hospital on 6/20/22. A pressure ulcer care plan was developed on 6/28/22 which was eight (8) days after the resident was readmitted to the facility. On 6/30/22 at 10:30 AM, during an interview with Licensed Practical Nurse (LPN) #2/Minimum Data Set (MDS)/Care Plan Nurse, she confirmed	F 656	All residents have the potential to be affected by this deficient practice. The Administrator completed an in-service with the Minimum Data Set Coordinator and Interdisciplinary Team on 7/18/2022. The in-service between Administrator and Minimum Data Set Coordinator and Interdisciplinary Team covered RAI guidelines for care plan completion, and facility care plan policy. The Minimum Data Set Nurse completed a 100 percent audit of residents care plans on 7/20/2022 to ensure all diagnosis and wounds are care planned and made revisions as necessary. The Director of Nursing will audit five care plans weekly to ensure all wounds have treatment orders for x four (4) weeks starting 7/18/2022 ending 8/15/2022, then monthly x 2 months starting 9/1/2022 ending 11/1/2022 document findings and take corrective action as needed. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee x four (4) months beginning 8/4/2022 ending 11/1/2022 for review, revision, and/or resolution of plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9	F 656		

she had not initiated a pressure ulcer care plan for Resident #4 because she had not been made aware that he had pressure ulcers when he was readmitted on 6/20/22. LPN #2 stated the care plan is to guide the staff on what to do to manage the care of the Residents. She stated she has not had time to catch up with the care plans.

On 6/30/22 at 11:00 AM, during an interview with the Director of Nursing (DON), she confirmed the care plan nurse failed to develop a pressure ulcer care plan. The DON said the care plan nurse did not know the resident currently had wounds because his previous wounds had healed prior to his hospitalization.

Record review of the "Admission Record" revealed the facility admitted Resident #4 on 3/17/2022 with diagnoses including Spina Bifida and Neuromuscular dysfunction of bladder.

Resident #35

A record review of Resident #35's "Order Summary Report" revealed a Physician's Order dated 1/20/2022 for "Apixaban Tablet 2.5 mg Give 1 tablet by mouth two times a day for anticoagulant".

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/22 revealed in Section N that Resident #35 received an anticoagulant medication for 7 days of the look back period. A review of Section I revealed that Resident #35 had active diagnoses including Hypertension, COPD and DM.

A record review of Resident #35's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10	F 656		

Comprehensive Care Plan revealed there was no care plan developed to include goals and interventions for the use of an anticoagulant medication as per the MDS completed 5/26/22. There was no Comprehensive Care Plan developed to include goals and interventions for the active diagnoses of Hypertension, COPD, or DM as per the MDS completed 5/26/22.

A record revie of the "Admission Record" revealed the facility admitted Resident #35 on 12/8/21 with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Essential Primary Hypertension, Type 2 Diabetes Mellitus (DM) with Hyperglycemia, and Chronic Obstructive Pulmonary Disease (COPD).

Resident #39

A record review of the "(Proper Name of Corporate) Baseline Care Plan - V3 (Version 3)" with an effective date of 5/20/22 and an admission date of 5/20/22, revealed Resident #39 had a baseline care plan completed.

A record review of Resident #39's Admission MDS revealed the comprehensive assessment had an ARD of 5/26/22.

A record review of Resident #39's comprehensive care plans revealed there were no comprehensive care plans developed after the comprehensive MDS was completed on 5/26/22.

A record review of the "Admission Record" revealed the facility admitted Resident #39 on 5/20/22, with diagnoses including Essential Primary Hypertension, Diabetes Mellitus due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 Underlying Condition with Diabetic Amyotrophy, and Chronic Obstructive Pulmonary Disease (COPD). On 06/29/22 at 1:35 PM, in an interview with Licensed Practical Nurse (LPN) #2, Minimum Data Set (MDS)/Care Plan Nurse, she stated that care plans are not up to date because she has not had time to complete them. She said that care plans are used by staff to give care to the residents. On 6/30/22 at 10:50 AM, during an interview with the Director of Nursing, she stated the MDS nurse is responsible for care plans and care plans are needed so that the staff will know how to meet the residents' specific needs. On 06/30/22 at 11:38 AM, the State Agency (SA) conducted an interview with the Administrator. He stated that the MDS Nurse is responsible for comprehensive care plans. He commented that "It would be a struggle to give the proper care" without a baseline or comprehensive care plan.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review a facility policy review reveal the facility failed to provide treatment consistent with professional standards of practice to an existing pressure injury after re-admission to the facility for one (1) of three (3) residents reviewed for pressure ulcers. Resident #4 Review of the facility's policy, "Admission and Readmission" dated March 15, 2007, revealed, "With each admission and readmission the Admission Nursing Assessment should be done ...The assessments included should be completed on all admission, readmissions ...1. Admission Nursing Assessment to be completed with each admission and readmission..." Findings Include: During an interview on 6/27/22 at 12:56 PM with Resident #4 Mother revealed the resident returned to the facility from the local hospital on 6/20/22. The mother said the resident's pressure wound to the buttocks reopened while he was in the hospital, and she has not seen the wound since he left the hospital. Record review of Resident #4's "Progress Notes" with the "Type" listed as "Admission Summary" dated 6/20/22 at 17:16 (5:16 PM), revealed, "Patient admitted from (Proper Name of Local Hospital) ...stage III (Stage 3) sacral wound with wet to dry dressing CDI (Clean, Dry, Intact) ..."	F 686	Treatment orders were obtained by the Minimum Data Set Nurse for Resident# 4 on 6/29/2022. All residents have the potential to be affected by practice this deficient practice. The Director of nursing, Minimum Data Set Nurse, and Registered Nurse Manager completed a 100% body audit on all residents on 6/29/2022 to ensure all wounds have treatment orders with no negative findings. The Administrator in-serviced all Licensed Nurses on obtaining treatment orders on 7/20/2022. The Director of Nursing will complete audit to ensure treatment orders are in place for all wounds two (2) times weekly for four (4) weeks starting on 7/18/2022 ending on 8/15/2022 and then once (1) monthly x two (2) months starting 09/1/2022 ending 11/01/2022 document findings and take corrective action as needed. The Director of Nursing will report audits times four (4) months with Quality Assurance Performance Improvement Committee beginning 8/4/2022 ending 11/1/2022 for review, revision, and/or resolution of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13	F 686		

On 6/29/22 at 10:18 AM, during an observation of wound care and interview with LPN #3 and Registered Nurse (RN) #2, RN #2 said the sacral wound was a stage 4 pressure ulcer, presenting as a stage 3. LPN #4 confirmed the facility was not aware of the sacral wound and they did not have treatment orders in place from the time Resident #4 was readmitted to the facility on 6/20/22 until she had called the physician to obtain orders on 6/29/22 when the SA asked to observe wound care. LPN #3 stated she was not the wound nurse when Resident #4 returned from the hospital, and she was not aware at that time that he had any wounds.

Record review of Resident #4's Treatment Administration Record (TAR) for the month of June 2022, revealed, "Dakins (1/4 Strength) Solution 0.125% (Sodium Hypochlorite) Apply to sacral wound topically one time a day every Mon (Monday, Wed (Wednesday), Fri (Friday) for stage 3 pressure wound cleanse with dakins/normal saline, pat dry, pack with collagen, apply xeroform, and over with dry dressing" with a start date of 6/29/22. The nurse documented the treatment was administered on 6/29/22. There were no other treatments documented on the TAR prior to the documentation on 6/29/22, which was nine (9) days after Resident #4 was readmitted to the facility.

During an interview on 6/29/22 at 1:00 PM with LPN #3 confirmed she was the nurse on duty on 6/20/22. She took the report from the hospital that indicated Resident #4 had a stage 3 pressure ulcer to the sacrum and she charted it in the progress notes. LPN #3 said Resident #4 returned to the facility after 5:00 PM, and it was time for her to perform Accuchecks and assist the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14	F 686		

residents with dinner. LPN #3 confirmed she did not complete a head-to-toe assessment and did not observe or measure the resident's wounds. She reported off to the next shift that Resident #4 was a hospital return and she thought the oncoming nurse would complete the body audit and admission. She did not follow up to make sure the admission was completed when she returned for her next scheduled shift.

On 6/29/22 at 2:00 PM, during an interview with LPN #1, she confirmed she was the oncoming nurse on 6/20/22 for the evening shift on the day Resident #4 returned from the hospital. She did not finish the admission and she did not know Resident #4 had wounds because she did not complete a head-to-toe assessment. She thought LPN #2 or LPN #3 would finish the assessment the next day.

On 6/30/2022 at 11:00 AM, during an interview with the Director of Nursing (DON), she confirmed the facility failed to provide wound care treatment to Resident #4's sacral wound for eight (8) days after his re-admission to the facility. She stated LPN #3 was responsible for admitting Resident #4 which should have included assessing the wounds and receiving wound care orders to ensure the treatments were on the TAR. The DON also said LPN #1 should have finished the admission because the resident returned late in the afternoon. The DON was not aware that Resident #4 had wounds when he returned from the hospital and she completed the Admission Evaluation and a PAR (Problem-Action-Results) progress note on 6/28/22 for Resident #4.

A record review of the facility's "Admission and Re-admission Evaluation V-2 (Version 2)" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15 6/20/22 at 17:12 (5:12 PM), revealed " ...D. Skin Integrity ...2. Document any skin concerns ...re-opened sacral area, r (right) heel unstageable, l (left) heel". Record review of Resident #4's "Progress Notes" with the "Type" listed as "PAR", dated 6/28/22 at 14:40 (2:40 PM), revealed, "PAR RT (Related To) Wounds: Resident readmitted from hospital 6/20/22 with noted unstageable wound to R (Right) heel. Also has Stage 3 to sacrum which is reopened area. Also noted with unstageable to L (Left) heel ..." During an interview on 6/30/22 at 11:30 AM, with the Administrator, he confirmed he did not know Resident #4 was readmitted to the facility with pressure wounds. The Administrator said he expected the nursing staff to follow the facility policy on admissions. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 3/17/2022 with diagnoses including Spina Bifida and Neuromuscular dysfunction of bladder. Record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/22 revealed Resident #4 required a staff assessment for mental status, and he is severely impaired in cognitive skills for daily decision making.	F 686		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16 §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 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 interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not labeled or dated with a Use-By date, and food items not discarded after the expiration date, for one (1) of two (2) kitchen observations. Findings Include: Review of the facility's policy "Labeling and Dating for Safe Storage of Food" with an expiration date of 3/6/2020 revealed, "Objective: Participants will learn that labeling and dating are critical to promote food safety. The use of Use-By dates will be reviewed. All products should be dated upon receipt. All products should be dated when opened. Use Use-By dates on all food once opened and stored under refrigeration ...Expiration dates supercede storage guide ..."	F 812	The Dietary Manager discarded all expired, undated, and improperly stored food items on 6/27/2022. All residents that receive a diet by mouth have the potential to be affected. The Dietary Manager completed an in-service for all dietary staff on 6/28/2022 regarding proper sanitation procedures, to include storage, labeling, dating and expired foods. The Dietary Manager will perform kitchen inspections x two (2) times weekly beginning on 7/19/2022, then weekly beginning on 8/15/2022, then monthly beginning on 9/1/2022 ending on 11/1/2022 to ensure all food items are dated, stored in a sanitary manner, and discarded upon expiration, document	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 On 6/27/22 at 11:25 AM, the State Agency (SA) conducted an initial tour of the kitchen with Dietary Manager #1 and observed the following: 1. In the Dry Storage room, there was a container of white bread with a label indicating a preparation date of 6/17/22 and a Use-By date of 6/24/22. 2. In the Dry Storage room, there was a container of wheat bread with a preparation date of 6/17/22 and a Use-By date of 6/24/22. 3. In the Dry Storage room, there was a container of Lemon Juice Reconstitute with an expiration date of 6/14/22. 4. In the Dry Storage room, there was a container of Sweetened Condensed Milk with an expiration date of 3/10/22. 5. In the Dry Storage room, there was a package of Ranch Dressing Mix House Recipe that was opened on the right edge of the package and was not sealed. There was no label indicating the date the package was opened. 6. In the Dry Storage room, there was a package of Ranch Dressing Mix House Recipe that was opened and sealed with a clip. There was no label indicating the date the package was opened. 7. In the Refrigerator, there was a zip lock bag that contained a head of lettuce. There was no label indicating the date the lettuce was stored and there was no Use-By date on the bag. 8. In the Refrigerator, there was a covered bowl of turkey sandwich meat. There was no label indicating the date the turkey was stored and there was no Use-By date on the bowl. 9. In the Refrigerator, there was a covered bowl of ham sandwich meat. There was no label indicating the date the ham was stored and there was no Use-By date on the bowl.	F 812	findings and take corrective action as necessary. The Dietary Manager will report findings from weekly and monthly inspection to the Quality Assurance and Performance Improvement Committee at the monthly meetings beginning 8/4/2022 and ending 10/4/2022 for review, revision, or resolution of plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18 On 6/27/22 at 11:52 AM, during an interview with the Dietary Manager (DM), she stated that she and the Assistant DM are responsible for discarding expired foods and ensuring food items are labeld with the opened date and Use-By date. On 6/28/22 at 10:00 AM, during an interview with the DM, she stated that expired food items could cause harm to the residents. She confirmed that food items should be checked daily for expired items and labeling. On 6/30/22 at 02:18 PM, during an interview, the Administrator stated that the residents are at risk for a possible illness if they consume expired food products. He stated that it is very important to check the dates on food and that he does not expect to find expired items in the kitchen. Record review of an "Associate In-Service Record", dated 12/14/21, revealed "Points Covered/Overview ...receiving and storage of food ..." revealed dietary staff received training on storage of food items.	F 812		