

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24GC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2023
NAME OF PROVIDER OR SUPPLIER COASTAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 BROAD AVE GULFPORT, MS 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations at the facility from 2/22/23 through 3/6/23 for (CI) MS #20555 for falls, resident safety, and incontinent care, CI MS #20778 for nursing services and environment, CI MS #20860 for resident assessment, call lights not answered timely, resident not turned, resident not treated with dignity/respect, CI MS #20893 regarding resident not turned or repositioned and pressure sores, and CI MS #20896 for environment, services not performed per the plan of care and physician, administration, infection control, misappropriation, dietary services, and resident not groomed and no deficiencies were cited. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M615 related to CI MS #20861 for no pressure sore precautions, treatments, pressure sores, and CI MS #20794 for no pressure sore precautions, infection control, and environment and cited M640. The SA identified an Immediate Jeopardy (IJ) that began on 2/22/23 when Resident #1 was observed with his right foot wedged between the mechanical bed's footboard and the mattress. Additionally, on 2/23/23, the SA observed Certified Nurse Aide (CNA) #1 using a full body mechanical lift with Resident #2 suspended midair in a sling, without an additional staff assistance. The facility Administrator was notified of the IJ on 2/23/23 at 1:45 PM. The IJs existed at:	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/27/23

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M 000	Continued From page 1 Rule 45.21.8-(M640) Accidents The facility provided an acceptable Removal Plan on 2/24/23, in which they alleged all corrective actions to remove the IJ were completed and the IJ removed on 2/24/23. The SA validated the Removal Plan on 2/27/23 and determined the IJ was removed on 2/24/23, prior to exit. Due to additional complaints received, the Surveyor returned to the facility on 2/28/23 and extended the survey. The SA identified an additional IJ, that began on 2/7/23 when the facility's treatment nurse resigned and was not replaced, which led to pressure ulcer treatments and wound assessments being inconsistently performed and documented. The SA notified the Administrator that the IJ Template dated 2/23/23 and the Removal Plan dated 2/24/23 were being rescinded. The IJ existed at: Rule 45.21.3- (M615) Pressure Sores The facility Administrator was notified of the IJ and presented a revised IJ Template on 3/2/23 at 5:10 PM. The facility submitted an acceptable Removal Plan on 3/4/23, in which they alleged all corrective actions to remove the IJ were completed as of 3/2/23 and the IJ removed on 3/3/23. The SA validated the Removal Plan on 3/6/23 and	M 000		

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M 000	Continued From page 2 determined the IJ was removed on 3/3/23, prior to exit. Therefore, the scope and severity for M 615 was lowered from a Level IV to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 114, and the facility held a license for 180 beds.	M 000		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level IV Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were assessed and routine and consistent Pressure Ulcer (PU) care, assessments, and documentation related to PUs were completed for four (4) of five (5) residents reviewed for PUs. (Resident # 4, Resident #5, Resident #6, and Resident #7). The facility's failure to provide routine and consistent wound care, wound assessments, and wound documentation put Resident #4, Resident #5, Resident #6, and Resident #7 and all other residents who are at risk for skin breakdown at risk for serious harm, injury, impairment, or death.	M 615	*On 3-1-23 at 11:30am, Registered Nurse (RN) #7 completed skin audit on resident #7 with no new finding noted. On 3-2-23 at 10:00am, Resident #4, Resident #5 and Resident #6 are not currently in the center and unable to be assessed. *Beginning on 3-1-23 at 11:30am body audits initiated and completed on 3-2-23 by 9:00pm by RN #2, RN #3, RN #4, RN #5, RN #7, RN #8 and Licensed Practical Nurse (LPN) #1, for current in house residents on census to determine stages of wounds. LPN #1 observed residents	3/28/23

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M 615	Continued From page 3 The situation was determined to be an Immediate Jeopardy (IJ) that began on 2/7/23 when the facility's treatment nurse resigned and was not replaced, which led to PU treatments and wound assessments being inconsistently performed and documented. The facility Administrator was notified of the IJ and presented an IJ Template on 3/2/23 at 5:10 PM. The facility provided an acceptable Removal Plan on 3/4/23, in which they alleged all corrective action to remove the IJ was completed and the IJ removed on 3/3/23. The SA validated the Removal Plan on 3/6/23 and determined the IJ was removed on 3/3/23, prior to exit. Therefore, the scope and severity for Rule 45.21.3 (M615) Pressure Sores was lowered from a "Level IV to an "Level II", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A record review of the facility's policy "Skin and Wound" with a revision date 01/24/2021 revealed, "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries. Process: Pressure Injury Prevention: 1. Resident's skin will be evaluated upon admission/re-admission and documented in the medical record. 2. Nurse to complete skin evaluation and document in the medical record. 3. CNA (Certified Nurse Aide) to complete skin observations and report changes to nurse ...Skin Impairment Identification: 1. Document	M 615	without identified skin concerns with instructions to notify RN if skin concerns identified. Results of the body audit identified an additional three (3) resident with four (4) new wounds. *RN #1 reviewed treatment orders to ensure appropriate treatment on 3-3-23. On 3-2-23, RN#10 and LPN #2 completed Braden Scale on current in house residents. RN #8 updated CNA Task in the electronic medical record with turning and repositioning for current residents so CNAs can document turning and repositioning on 3-2-23. On 3-2-23, RN #1 completed Wound □ Weekly Observation Tools for seventeen (17) residents with a total of thirty-five (35) wounds. On 3-2-23 at 6:00pm, Executive Director (ED) /RN#1 initiated education to all nurses regarding wound identification and treatment to include, admission / readmission body audit, completing Braden Scale Assessment, notifying provider for treatment if wound is identified, completing treatment as ordered if treatment nurse is not available, ensure documentation is completed on electronic treatment administration record (eTAR) and completing weekly skin checks. No current licensed nurses or new hired licensed nurse will work without the aforementioned education.	

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M 615	Continued From page 4 presence of skin impairment(s)/new skin impairment(s) when observed. 2. Nurse to report changes in skin integrity to the physician/physician extender, resident/resident representative and document in the medical record ...4. Monitor residents' response to treatment, modify as indicated ..." Resident #4 Record review of the "Admission Record" revealed the facility admitted Resident #4 on 08/09/2022 with diagnoses of Paraplegia, Pressure Ulcer of Sacral Region Stage 4, and Type 2 Diabetes Mellitus with Hyperglycemia. At 10:00 AM on 02/28/23, during an interview with CNA #13, she reported Resident #4 would sometimes complain about night shift not turning him, but she was unable to recall exactly when or who he had complained about. She said that Resident #4 would request that his wound care be completed daily before he got up. CNA #13 stated that the resident had a bad wound to his buttocks and to his foot and he complained that the nurses were not doing his wound care. On 02/28/23 at 10:20 AM, during an interview with Licensed Practical Nurse (LPN) #9, she explained Resident #4 spoke very little English but could make his needs known. He was admitted to the facility with a wound to his coccyx, and he complained that the facility was not completing his wound care daily as he expected. Resident #4 Sacrum Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated	M 615	On 3-2-23, at 6:05pm, ED/RN #1 initiated education with CNAs regarding nurse notification if a skin concern is identified and following chain of command if nurse is unavailable. No current CNA or newly hired CNA will work without the aforementioned education. On 3-2-23, at 5:30pm, the Quality Assurance Performance Improvement (QAPI) Committee met to revise the Performance Improvement Plan for AD Hoc QAPI meeting dated 2-21-23 to conduct RCA and to create Removal Plan for Immediate Jeopardies received regarding F686 Treatment / Services to Prevent / Heal Pressure Ulcers. Policies and Procedures reviewed: Skin and Wound Guidelines, Plan of Care, Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in Condition which required no changes. Reviewed Policy and Procedure Maintenance with changes made in the notification procedure to implement maintenance repair request form. *Facility will ensure wound identification / management / treatment as necessary for residents. Observation rounds will be conducted by Registered Nurse (RN) beginning on 3-3-23 five (5) residents per week for four (4) weeks and then five (5) residents per month for three (3) months. Findings will be brought to the QAPI Committee Meeting by Assistant Director of Clinical Services on March 28, 2023 to discuss finding and make necessary	

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M 615	Continued From page 5 11/17/22 for "Acetic Acid Solution 0.25% Apply to sacrum topically every day shift for sacrum." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed "Acetic Acid Solution 0.25% Apply to sacrum topically every day shift for sacrum" was not documented as administered on 2/3/23, 2/4/23, 2/5/23, 2/8/23, 2/9/23, 2/10/23, 2/11/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/18/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, and 2/24/23, which was a total of 20 missed wound treatments. Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated 12/30/22 to "Cleanse Sacrum with NS/Wound Cleanser, pat dry, Apply Puraply Skin sub x 2. cover with zeroform and border dressing leave on for 7 days. If border dressing comes loose, change only outer border dressing one time a day and as needed for sacrum." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed, "Cleanse Sacrum with NS/Wound Cleanser, pat dry, Apply Puraply Skin sub x 2. cover with zeroform and border dressing leave on for 7 days. If border dressing comes loose, change only outer border dressing one time a day and as needed for sacrum" was not documented as administered on 2/3/23, 2/4/23, 2/5/23, 2/8/23, 2/9/23, 2/10/23, 2/11/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, and 2/24/23, which was a total of 19 missed wound treatments. Review of the medical record revealed there were no weekly wound assessments or documentation	M 615	changes as indicated, then monthly times three months.	

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M 615	Continued From page 6 for the month of February 2022 to include wound measurements, characteristics, and progression of the wound to the sacrum. A record review of "Skin Substitute Application" for Resident #4 with date and time 1/26/23 at 0902 AM revealed " ... Sacrum size (cm) LxWxD (length x width c depth) 5.3 x 5 x 1.6 cm Type: Pressure Injury ... Stage IV Pressure Injury Full Thickness damage extends to muscle, bone, and/or tendon ..." A record review of "(Proper Name of Wound Care)" for Resident #4 with date of service on 01/26/23. " ...Chief complaint sacral pressure Stage IV. HPI (history personal information) Following for ongoing pressure wound greater than six (6) months. Completed IV (intravenous) antibiotics. Has had diarrhea for two (2) or three (3) weeks. This has greatly lessened, improved, adequate diet, small area of bruising at wound base, encouraged turning side to side only. Wound status: Improved Pain: mild/intermittent ..." A record review of "Progress Note Details" for Resident #4 dated 02/08/2023 by the Wound Care Nurse Practitioner (WCNP) revealed " ... Wound Assessment (s) Wound #1 Sacral is a Stage 4 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 4.56 cm length x 2.42 cm width x 1.5 cm depth, with an area of 11.035 sq (square) cm and a volume 16.552 cubic cm. Tunneling has been noted at 3:00 with a maximum distance of 2.924 cm. There is a Moderate amount of serosanguineous drainage noted which has no odor. Wound bed 76-100% granulation, 1-25% slough. The wound is improving."	M 615		

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M 615	Continued From page 7 Resident #4 Left Lateral Ankle Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated 12/21/22 to "Cleanse left lateral ankle with NS (normal saline)/Wound cleanser, pat dry, apply dura-fiber AG (silver), cover with silicone foam border dressing Monday, Wednesday, Friday and PRN (as needed) for left lateral ankle". A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed, "Cleanse left lateral ankle with NS/Wound cleanser, pat dry, apply durafiber AG, cover with silicon foam border dressing Monday, Wednesday, Friday and PRN one time a day ..." was not documented as administered at 9:00 AM on 2/3/23, 2/8/23, 2/10/23, 2/13/23, 2/15/23, 2/17/23, 2/20/23, 2/22/23, and 2/24/23, which was a total of 9 missed administrations. Resident #4 Right Dorsal Foot Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated 12/22/22 to "Cleanse right dorsal foot with NS/Wound cleanser, pat dry, apply dura-fiber AG, cover with silicone foam border dressing Monday, Wednesday, Friday, and PRN ..." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed, "Cleanse right dorsal foot with NS/Wound cleanser, pat dry, apply dura-fiber AG, cover with silicone foam border dressing Monday, Wednesday, Friday, and PRN" was not documented as administered at 9:00 AM on	M 615		

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M 615	Continued From page 8 2/3/23, 2/8/23, 2/10/23, 2/13/23, 2/15/23, 2/17/23, 2/20/23, 2/22/23, and 2/24/23, which was a total of 9 missed administrations. Resident #4 Right Heel Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated 12/21/22 to "Cleanse Right Heel with NS/Wound Cleanser, pat dry, apply durafiber AG, cover with silicone foam border dressing Monday, Wednesday, Friday and PRN as needed for Right Heel deep tissue injury." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed, "Cleanse Right Heel with NS/Wound Cleanser, pat dry, apply durafiber AG, cover with silicone foam border dressing Monday, Wednesday, Friday and PRN as needed for Right Heel deep tissue injury" was not documented as administered at 9:00 AM on 2/3/23, 2/8/23, 2/10/23, 2/13/23, 2/15/23, 2/17/23, 2/20/23, 2/22/23, and 2/24/23, which was a total of 9 missed administrations. Resident #4 Right Second Toe Record review of the "Order Summary Report" with "Active Orders As Of 02/28/2023 revealed Resident # 4 had a Physician's Order dated 1/2/23 to "Cleanse wound to Right second Toe with NS/Wound Cleanser, pat dry, apply zeroform cover with dressing Every Monday, Wednesday, Friday one time a day ..." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 revealed, "Cleanse wound to Right second Toe	M 615		

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M 615	Continued From page 9 with NS/Wound Cleanser, pat dry, apply zeroform cover with dressing Every Monday, Wednesday, Friday one time a day ..." was not documented as administered at 9:00 AM on 2/3/23, 2/8/23, 2/10/23, 2/13/23, 2/15/23, 2/17/23, 2/20/23, 2/22/23, and 2/24/23, which was a total of 9 missed administrations. Record review of the Quarterly "Braden Scale For Predicting Pressure Sore Risk" for Resident #4, dated 11/14/2022 revealed he had scored an "11" which placed him in the "High Risk" category for developing pressure ulcer. Record review of "Progress Notes" for Resident #4 with effective date 2/24/23 at 9:10 PM revealed "Resident transferred to ER (emergency room) by (Proper name of ambulance service). Resident was bleeding from catheter site..." A record review of "Physician/Prescriber Telephone Orders" for Resident #4 revealed " ... send resident to (Proper name of hospital) ER (Emergency Room) for eval (evaluation) and Tx (treat) RE: (regarding: bleeding from Cath (catheter) site ..." Review of the medical record for Resident #4 revealed there were no weekly wound assessments or documentation for the month of February 2023 to include wound measurements, characteristics, and progression for any of his wounds. At 12:30 PM on 02/28/23, during an interview with the Administrator, she explained the current Director of Nursing (DON) continued to work a medication cart on the night shift and RN #1 was stepping in to assist with the survey. The Assistant Director of Nursing (ADON) had resigned and his last day at the facility was	M 615		

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M 615	Continued From page 10 02/24/23. She explained the Quality Assurance Performance Improvement (QAPI) meeting held on 02/21/23 was concerning the facility's wound process including weekly wound reports, weekly skin audits, wound care, and anything dealing with the wound process. She reported the current DON was responsible for completing the weekly wound reports and the LPNs on the medication carts were responsible for weekly skin audits, but the DON oversaw making sure the skin audits were completed. During an interview at 4:00 PM on 02/28/23, with RN #13 (Acute Hospital Nurse), she explained Resident #4 was currently a patient in the acute hospital and was admitted with wounds to his sacrum and feet. On 2/28/23 at 4:05 PM, during an interview with Social Worker (SW) #1 (Acute Hospital Social Worker), she explained Resident #4 does not want to go back to the facility and had asked to be placed somewhere else. Resident #4 told her he was not getting wound care and was not getting turned. On 2/28/23 at 4:10 PM, during an observation and interview with Resident #4, he was in bed wearing a gown with air pressure devices on both lower legs and feet. He stated that he was "afraid he was going to die in the facility" and he did not want to return. He said that the staff did not turn him, especially the night shift, and he was unable to turn himself completely over because he was paralyzed from the waist down. He complained that he was left up for "hours at a time" in his wheelchair even after he had requested to be placed back in bed and he had not received wound care for two (2) weeks.	M 615		

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(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) COMPLETE DATE
M 615	Continued From page 11 Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/2023 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section G revealed he required extensive two-person assistance for bed mobility and was totally dependent upon two staff members to assist with transfers. At 04:30 PM on 02/28/23, during a phone call with Resident #4's interpreter, he explained Resident #4 had complained that he was not getting wound care at the nursing home. On 03/01/23 at 10:00 AM, during an interview with RN #1, he confirmed the last Braden Scale For Predicting Pressure Sore Risk for Resident #4 was completed on 11/14/2022 and that the Braden Scale should be completed on admission, re-admission, quarterly, and with a significant change resident assessment. On 03/01/23 at 1:30 PM, during an interview with RN #1, he explained the facility used the "Wound-Weekly Observation Tool" to document measurements and characteristics of resident wounds, including pressure ulcers and that they should be completed weekly. He confirmed that Resident #4 did not have any weekly wound documentation completed for the month of February 2023. Resident #5 At 11:45 AM on 02/28/23, during an interview with CNA #15, she explained Resident #5 was in the hospital, but she had provided care to Resident #5 while he was at the facility. She stated that he a bad wound on his back side and there was a	M 615		

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M 615	Continued From page 12 large amount of drainage and an odor. She said that she had reported to the ADON and the DON several times regarding the increased drainage and odor. Record review of "Physician/Prescriber Telephone Orders" for Resident #5 dated 02/26/23 at 11:19 AM revealed " ... Send resident to ER (Emergency Room) for eval (evaluation) & TX (Treatment) RE: Resident pulled out foley catheter ..." Record review of Resident #5's "Admission Record" revealed the facility admitted resident on 02/14/23 with the diagnoses of Osteomyelitis, Sepsis, Elevated White Blood Cell Count, Unspecified, Metabolic Encephalopathy, Acute Cystitis with Hematuria, and Paraplegia. Record review of " ...Admission/Readmission Date Collection" documentation form, dated 2/14/23, for Resident #5, revealed, " ...M. Skin ... Right Knee (front) has open area lateral knee approx. (approximately) 17 mm x 10 mm ...Right lower leg (front) scabbed over area approx. 6 mm x 2 mm at largest spot ...Right ankle (outer) open area red approx. 6 mm x 3.5 mm ...Sacrum has large open area ... Concerns on Feet ...right toe (s) missing 1st and fifth digit, forth digit red and open from burn." The document did not include the type of wounds (Pressure/Non-pressure) and there were no measurements or wound characteristics for the sacral wound. Resident #5 Right Anterior Lower Leg Record review of the "Order Recap Report", with order dates from 2/1/23 through 2/28/23, revealed there were no Physician's Orders for treatment to the Right Anterior Lower Leg.	M 615		

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M 615	Continued From page 13 Record review of the "Progress Notes Details", dated 2/17/23, completed by Wound Care Nurse Practitioner (WCNP), "Right, Anterior Lower Leg ...Pressure Ulcer ...Not Healed. Initial wound encounter measurements are 3.87 cm length x 2.47cm width x 0.17 cm depth ...There is a small amount of sero-sanguineous drainage noted which has no odor. Wound bed has 26-50% slough, 26-50% eschar ..." The WCNP did not indicate any new orders for the right anterior lower leg. Resident #5 Sacrum Record review of the "Order Recap Report", with order dates from 2/1/23 through 2/28/23, revealed a Physician's Order dated 2/14/23 for "Povidone-Iodine External Solution 10%...Apply to sacrum topically one time a day for wound for 7 days." There were no Physician Orders to treat the sacral wound from the time the order was completed (2/22/23) until Resident #5 was transferred to the hospital on 2/26/23, which was four days. Record review of the "Progress Notes Details", dated 2/17/23, completed by Wound Care Nurse Practitioner (WCNP), " ...Sacral is a Stage 4 Pressure Injury Pressure Ulcer ...Not Healed. Initial wound encounter measurements are 18.08cm length x 33.76cm width x 5.82 cm depth ...Muscle and bone are exposed. There is a Large amount of green drainage noted which as a Strong odor. Wound bed has 51-75% granulation, 26-50% slough ...Wound Orders ...Pack wound with Acetic Acid 0.25%...Every day for 15 days ..." Review of the medical record revealed the wound	M 615		

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M 615	Continued From page 14 care orders dated 2/17/23 by the WCNP were not executed by the facility. Resident #5 Right Lateral Hip Record review of the "Order Recap Report", with order dates from 2/1/23 through 2/28/23, revealed a Physician's Order dated 2/14/23 for "Menthol-Zinc Oxide External Ointment ...Apply to penis, scrotum, hip/thigh topically three times a day for infection. Apply 1 g (gram) topically in the morning, 1 g at noon, and 1 g before bedtime. Cleanse with soap and water, pat dry, apply to penis, scrotum and redness on hip/thigh." Record review of the "Progress Notes Details", dated 2/17/23, completed by Wound Care Nurse Practitioner (WCNP), " ...Right, Lateral Hip is a Pressure Ulcer ...Not Healed. Measurements are 1.04cm length x 1.55cm width x 0.27 cm depth ...Wound Orders ...Pack wound with Acetic Acid 0.25%...Every day for 15 days ..." Review of the medical record revealed the wound care orders dated 2/17/23 by the WCNP were not executed by the facility. Resident #5 Right Posterior Thigh Record review of the "Order Recap Report", with order dates from 2/1/23 through 2/28/23, revealed a Physician's Order dated 2/14/23 for "Menthol-Zinc Oxide External Ointment ...Apply to penis, scrotum, hip/thigh topically three times a day for infection. Apply 1 g (gram) topically in the morning, 1 g at noon, and 1 g before bedtime. Cleanse with soap and water, pat dry, apply to penis, scrotum and redness on hip/thigh." Record review of the "Progress Notes Details",	M 615		

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M 615	Continued From page 15 dated 2/17/23, completed by Wound Care Nurse Practitioner (WCNP), revealed " ...Right, Posterior Thigh is a Pressure Ulcer ...Not Healed. Measurements are 1.86cm length x 2.28cm width x 0.42 cm depth ...Wound Orders ...Pack wound with Acetic Acid 0.25%...Every day for 15 days ..." Review of the medical record revealed the wound care orders dated 2/17/23 by the WCNP were not executed by the facility. Resident #5 Posterior Scrotum Record review of the "Order Recap Report", with order dates from 2/1/23 through 2/28/23, revealed a Physician's Order dated 2/14/23 for "Menthol-Zinc Oxide External Ointment ...Apply to penis, scrotum, hip/thigh topically three times a day for infection. Apply 1 g (gram) topically in the morning, 1 g at noon, and 1 g before bedtime. Cleanse with soap and water, pat dry, apply to penis, scrotum and redness on hip/thigh." Record review of the "Progress Notes Details", dated 2/17/23, completed by Wound Care Nurse Practitioner (WCNP), revealed, " ...Posterior Scrotum is a Stage 4 Pressure Injury Pressure Ulcer ...Not Healed. Initial wound encounter measurements are 6.16cm x 5.15cm width x 0.51 cm depth ...There is a Large amount of green drainage noted which as a Strong odor. Wound bed has 76-100% granulation, 51-75% slough ...Wound Orders ...Pack wound with Acetic Acid 0.25%...Every day for 15 days ..." Review of the medical record revealed the wound care orders dated 2/17/23 by the WCNP were not executed by the facility. Record review of the "Order Recap Report", with	M 615		

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M 615	Continued From page 16 order dates from 2/1/23 through 2/28/23, revealed a Physician's Order dated 2/14/23 for "Sodium Hypochlorite External Solution ...Apply to wound topically two times a day for skin disinfection". The order did not indicate the wound location to apply the solution. Review of the electronic TAR revealed for 2/1/23 through 2/28/23 revealed Sodium Hypochlorite External Solution ...Apply to wound topically two times a day for skin disinfection" was not documented as administered for the 9:00 AM treatment on 2/16/23, 2/17/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/24/23, 2/25/23 and for the 5:00 PM treatment on 2/15/23, 2/16/23, 2/17/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/24/23, and 2/25/23, which was a total of 17 treatment administrations. Review of the medical record for Resident #5 revealed there were no weekly wound assessments or documentation for the month of February 2023 to include wound measurements, characteristics, and progression for any of his wounds. There was also no Braden Scale For Predicting Pressure Sore Risk Braden Scale (used to assess pressure ulcer risk factors) in the medical record for Resident #5. On 02/28/23 at 12:20 PM, during an interview with RN #1, he confirmed there had not been a Braden Scale completed for Resident #5 upon admission. Record review of Resident #5's Admission MDS with an ARD of 2/21/23 revealed Resident #5 had a BIMS score of 15, which indicated he was cognitively intact. Section G revealed he needed extensive assistance with two staff for bed mobility and transfers.	M 615		

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M 615	Continued From page 17 On 2/28/23 at 3:10 PM, during an interview with Resident #5 at an acute care hospital, he stated that he did not believe his wounds were treated consistently and while at the facility, he noticed his wound was draining more than usual and the nurses at the facility complained the drainage from the wound smelled like urine, but "no one ever did anything about it." On 3/01/23 at 1:30 PM, during an interview with the RN #1, he confirmed the facility did not execute wound care orders from the WCNP as listed on her progress notes on 2/17/23. He also confirmed there were no active Physician Orders for Resident #5 for the Stage 4 Pressure Ulcer to the sacrum from 2/22/23 through 2/26/23. He expected nurses to complete wound care as ordered and to notify him and document any resident refusals for treatment. RN #1 verified that Resident #5 had no weekly wound assessments or weekly skin evaluations completed from the date of admission (2/14/23) through the date he was admitted to an acute care hospital (2/26/23). 3/02/23 at 3:40 PM, during a phone interview with the facility's WCNP, she stated that she had written wound care orders for Resident #5 on the day she assessed him. She expected the wound care orders to be carried out and wound care to be provided as ordered. Resident #6 Record review of the "Admission Record" revealed the facility admitted Resident #6 on 01/16/23 with the diagnoses of Paraplegia, Unspecified, Urinary Tract Infection, Site not Specified, and Pressure-Induced Deep Tissue	M 615		

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M 615	Continued From page 18 Damage of Sacral Region. Review of the medical record for Resident #6 revealed there was no "...Admission/Readmission Data Collection" form completed that addressed the resident's skin condition at the time of admission. Record review of the " ...Weekly Integrity Review ...", dated 1/17/23, revealed, " ...Weekly skin evaluation ...Sacrum ...Small area of redness 1cmX1cm ...Wound care aware No other wounds or open areas noted ..." Record review of the "Order Summary Report" with "Active Orders As Of: 03/08/2023" revealed a Physician's Order, dated 1/18/23 to "Apply house barrier cream to sacrum after each incontinent episode. Every shift for Preventive." Record review of the " ...Weekly Integrity Review ...", dated 2/6/23, revealed, " ...Weekly skin evaluation ...Sacrum ...90% black wound bed, spots of bleeding ...Wound care aware ..." Record review of the "Order Summary Report" with "Active Orders As Of: 03/08/2023" revealed a Physician's Order, dated 2/6/23 to "Cleanse Sacrum with NS/Wound cleanser, pat dry, Apply santyl with Vashe wet to dry, cover with Foam border dressing QD (Every Day) and PRN..." A record review of the "Progress Note Details", dated 02/08/23, completed by the facility's WCNP revealed " ... Wound Assessment(s) Wound #1 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer ...Not Healed. Initial wound encounter measurements are 14.54cm length x 12.79cm width x 0.1 cm depth ... There is a	M 615		

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M 615	Continued From page 19 Large amount of purulent drainage noted which has a Strong odor ... Wound Orders ...Apply wound with Collagenase Santyl Ointment 30 g every day for 15 days ..." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 for Resident #6 revealed, "Cleanse Sacrum with NS/Wound cleanser, pat dry, Apply santyl with Vashe wet to dry, cover with Foam border dressing QD (Every Day) and PRN..." was not documented as administered at 9:00 AM on 2/8/23, 2/9/23, 2/10/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/18/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, and 2/24/23, which was a total of 16 missed administrations before Resident #6 was admitted to the hospital on 2/24/23. On 03/01/23 at 11:40 AM, during a phone interview with Resident #6's sister who is the Resident Representative (RR), she stated that when Resident #6 was admitted to the facility, he did not have any open areas to his buttocks. She reported the area to his buttocks started out with redness and kept getting worse to the point to where the wound had a black discoloration. She said she could not get anyone at the facility to talk to her about her brother's wound and that staff was not turning the resident. She stated that the facility's CNAs commented that "it was the worse they had ever seen" and the hospital staff commented that the wound "was bad." She said the wound was debrided at the hospital on 02/28/23 and Resident #6 was getting a colostomy today (3/1/23) to help in wound healing. Record review of Resident #6's "Physician/Prescriber Telephone Orders", dated	M 615		

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M 615	Continued From page 20 2/24/23 revealed an order for "send resident to ER (emergency room) ...for eval (evaluation) and tx (treatment) ..." A record review of Resident #6's "Wound Care Consultation" from the hospital dated 02/25/23 revealed " ... Reason for consultation ...sacrum-large unstageable pressure ulcer, large green/black necrotic tissue, positive odor ..." During an interview with RN #1 on 03/01/23 at 2:05 PM, he confirmed there had not been a Braden Scale completed for Resident #6 upon admission to assess his risk for developing pressure ulcers. RN #1 verified that Resident #6 had no weekly wound assessments and one (1) weekly skin evaluation completed for the month of February 2023. He stated that the LPNs are to complete weekly skin evaluations and the DON should complete the weekly wound assessments. A record review of the Admission MDS with an ARD of 01/23/23 revealed Resident #6 had a BIMS score of 15, which indicated he was cognitively intact. Section G revealed he required extensive assist of two staff members for bed mobility and transfers. At 3:15 PM on 3/01/23, during an interview with Resident #6, in the acute hospital, he stated when he first went to the facility, he had no open areas on his skin. He said he felt like the night shift got "very lazy" and they began increasing the increments of turning him from every two (2) hours to every six (6) hours. He reported that his wound care was not completed daily and there were some weeks he did not receive wound care at all. He said that only certain nurses would do his wound care and his wound got worse and staff would "leave him up for hours" in his	M 615		

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M 615	Continued From page 21 wheelchair. At 3:30 PM on 03/01/23, during an interview with the Acute Hospital Social Worker #4, he explained that the pressure ulcer for Resident #6 had been debrided and is treated with a wound vacuum system. Resident #6 is also scheduled to have an ostomy in place to help with wound healing. At 1:15 PM on 03/02/23, during an interview with CNA #15, she explained Resident #6 did not have any wounds when he was first admitted to the facility, but then he developed redness about the size of a golf ball that went from white discoloration to black discoloration. She said that before Resident #6 was transferred to the hospital, the wound was all black, draining, and had an odor and she had informed the nurses and the ADON. Resident #7 A record review of "Admission Record" revealed the facility admitted Resident #7 on 02/01/23 with diagnoses including Diffuse Traumatic Brain Injury with loss of Consciousness Greater than 24 hours without Return to Pre-Existing Conscious Level with Patient Surviving, Subsequent Encounter and Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage Affecting Right Dominant Side. Record review of the Five (5) Day MDS with an ARD of 2/08/23, revealed Resident #7 was severely impaired with cognitive skills for daily decision making. Review of Section M revealed he had no unhealed pressure ulcers/injuries. At 11:50 AM on 2/28/23, during an interview with	M 615		

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M 615	Continued From page 22 Resident #7's girlfriend, she stated that the resident was not being turned and he had gotten two (2) wounds since his admission to the facility on 2/1/23. She said he had gotten a bed sore on his buttocks, but she was putting cream on the area to keep it from getting worse. On 3/02/23 at 1:00 PM, during an interview and observation of wound care of by RN #1, Resident #7 had a wound to the bony prominence near the right small toe. The area had a brown discoloration that was scabbed over. The sacrum was healed and did not have any open areas. RN #1 confirmed the wounds were acquired at the facility and that no weekly wound assessments were completed to stage, describe, or measure the wounds. At 1:15 PM on 3/02/23, during an interview with CNA #15, she explained when Resident#7 first was admitted to the facility he did not have any wounds or open areas. She stated she informed the nurses and the DON when he developed an open area to his buttocks and foot. On 3/02/23 at 1:30 PM, during an interview with CNA #12, she explained Resident #7 did acquire a wound to his buttocks and his foot after admission, and still has the wound to his foot. Resident #7 Right Outer Foot A record review of the "Order Summary Report" with "Active Orders As Of: 02/28/2023" revealed a Physician's Order dated 2/6/23 to "Cleanse Right Outer Foot with NS/Wound cleanser, pat dry, apply betadine and cover with foam border dressing QOD (every other day) and PRN (as needed) one time every Mon (Monday), Wed (Wednesday), Fri (Friday) for Right foot".	M 615		

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(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) COMPLETE DATE
M 615	Continued From page 23 A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 for Resident #7 revealed, "Cleanse Right Outer Foot with NS/Wound cleanser, pat dry, apply betadine and cover with foam border dressing QOD (every other day) and PRN (as needed) one time every Mon (Monday), Wed (Wednesday), Fri (Friday) for Right foot" was not documented as administered at 9:00 AM on 2/8/23, 2/10/23, 2/13/23, 2/15/23, 2/17/23, 2/20/23, 2/22/23, and 2/24/23, which was a total of eight (8) missed administrations. Resident #7 Sacrum A record review of the "Order Summary Report" with "Active Orders As Of: 02/28/2023" revealed a Physician's Order dated 2/6/23 to "Cleanse Sacrum area with NS/Wound cleanser, pat dry, apply durifiber AG (silver) and cover with foam border dressing QD and PRN as needed for sacrum ..." A record review of the electronic "Treatment Administration Record" for 2/1/23 through 2/28/23 for Resident #7 revealed, "Cleanse Sacrum area with NS/Wound cleanser, pat dry, apply durifiber AG (silver) and cover with foam border dressing QD and PRN as needed for sacrum ..." as administered at 9:00 AM on 2/8/23, 2/9/23, 2/10/23, 2/11/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/24/23, 2/25/23, and 2/28/23 which was a total of 17 missed administrations. Record review of the " ... Weekly Integrity Review ...", dated 2/6/23, revealed, " ... Weekly skin evaluation ...Right ankle (outer) ...Right outer foot ...Sacrum ...Redness ...Wound care aware ..."	M 615		

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M 615	Continued From page 24 Review of the medical record for Resident #7 revealed there were no weekly wound assessments or documentation for the month of February 2023 to include wound measurements, characteristics, and progression for any of his wounds. There was also no Admission/Readmission Data Collection documentation to document the resident's skin condition at the time of admission to the facility. On 03/02/23 at 10:00 AM, in an interview with RN #1, he confirmed Resident #7 did not have a Braden Scale or Admission Data Collection Tool completed upon admission. The facility submitted the following acceptable Removal Plan on 03/4/23: Quality Assessment: On 2/21/2023, at 10:00am, an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee met to review / develop / implement wound care program. Attendees were Executive Director (ED), Director of Nursing (DON), Maintenance Director, Director of Rehabilitation (DOR), Assistant Director of Nursing / Infection Control Preventionist (ADON / ICP), Business Office Manager (BOM), Human Resources Director (HRD), Medical Director (MD) attended by phone. A review of policy and procedures were: Skin and Wound Guidelines. Areas discussed: Reeducation of staff regarding wound management / treatment, reeducation of staff on wound identification, reeducate nursing staff on wound documentation to include Licensed Nurse Weekly Skin Integrity form, completing Weekly Wound Observation Tool, completing and documenting body audit on	M 615		

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M 615	Continued From page 25 admission / readmission, one hundred (100) percent skin audits to ensure all wound are identified and treatment in place, reeducate certified nursing assistant on notifying nurse if skin concern is identified. On 2/23/2023, at 2:00pm, an Ad Hoc QAPI Committee met to conduct Root Cause Analysis (RCA) and create Removal Plan for Immediate Jeopardies received regarding F 656 -Develop / Implement Comprehensive Care Plan, F 684 Quality of Care and F 689 - Accidents / Supervision. Attendees were ED, DON, Maintenance Director, DOR, ADON / ICP, BOM, HRD, MD attended by phone. A review of policy and procedures were: Care Plan, Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in condition which required no changes. Reviewed policy and procedure "Maintenance" with changes made in the notification procedure to implement maintenance repair request form. Topics discussed include: reeducate all staff on notification to Maintenance or Administrator when bed not working properly, Maintenance director to check all beds to ensure working properly, all staff to notify nurse if blood is observed, bandage noted with blood, bandage not intact and nurse to properly assess resident for adverse reactions, Licensed Nurses to assess residents for active bleeding and address any adverse outcomes for residents on anticoagulant therapy, reeducate nursing staff for transferring resident in full body lift, reeducate nursing staff to follow care plan that reflects specific resident needs related to full body lifts, review and revise if indicated residents transfer / mobility status, review and revise if indicated eMAR for assessing resident for signs and symptoms regarding anticoagulant therapy.	M 615		

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M 615	Continued From page 26 F 689, RCA determined the facility failed to properly identify an improper working bed with foot board not properly fitting bed due to staff failure of notification and additional need for education. All staff need additional training on how to report beds not properly working. RCA determined the facility failed to prevent possibility of injury by using full body sling with only one staff member, due to certified nurse assistant #1 failure to follow facility lift policy. F 684, RCA determined the facility failed to assess Resident #1 for four hours knowing there was blood on the floor, bandages not intact and saturated with blood, did not reassess after reporting the blood with resident on anticoagulant. RCA determined additional needs for education to all staff on notifying nurse of change in condition. RCA determined LPN #1 did not reassess for active bleeding and address the care related to resident on anticoagulant therapy and was educated by RN #1 on 02/22/2023 at 2:30 PM on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy. F 656, RCA determined the facility failed to properly follow Resident #2's care plan for a full body lift with two staff members to prevent the likelihood of a serious outcome by having resident dangling midair in the lift out in the hallway with no other staff members around. RCA determined Certified Nursing Assistant (CNA) #1 failed to follow facility policy and procedure related to care plan and received a corrective termination action on 02/23/2023 at 12:30 PM. On 3/2/2023, at 5:30pm, the QAPI Committee met to revise Performance Improvement Plan for Ad Hoc QAPI Meeting dated February 21, 2023 conduct Root Cause Analysis (RCA) and to create Removal Plan for Immediate Jeopardies F	M 615		

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M 615	Continued From page 27 686 Treatment / Services to Prevent / Heal Pressure Ulcers, F 684 Quality of Care and F 689 - Accidents / Supervision and F 656 Development / Implement Comprehensive Care Plan. Attendees were: MD, ED, DON, Regional Director of Clinical Services (RDCS), ICP, BOM, Medical Records Licensed Practical Nurse (LPN), Minimum Data Set Registered Nurse, Minimum Data Set Licensed Practical Nurse, Certified Nursing Assistant (CNA). Policies and Procedures reviewed: Skin and Wound Guidelines, Plan of Care. Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in condition which required no changes. Reviewed policy and procedure "Maintenance" with changes made in the notification procedure to implement maintenance repair request form. Areas discussed included: Continue education of staff regarding wound management / treatment, continue licensed nurse to complete admission / readmission body audit, completing Braden Scale assessment, notifying provider for treatment if new wound is identified, notifying resident representative if new wound or change in wound is identified, completing treatments if wound care nurse is not available, completing weekly Skin Integrity Review on residents, completing Wound Weekly Observation Tool on wounds, review and update Wound Care Plan as indicated for residents with current wounds or potential risk, review and update wound orders as indicated, reeducate certified nursing assistants regarding notification to nurse if skin concern is identified, review and revise if indicated schedule for Licensed Nurse Weekly Skin Integrity Review and update certified nursing assistant task for residents to include Turning and Repositioning every two (2) hours on residents with pressure ulcers and / or at risk for pressure ulcers.	M 615		

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M 615	Continued From page 28 F 689, RCA determined the facility failed to properly identify an improper working bed with foot board not properly fitting bed due to staff failure of notification and additional need for education. All staff need additional training on how to report beds not properly working. RCA determined the facility failed to prevent possibility of injury by using full body sling with only one staff member, due to certified nurse assistant #1 failure to follow facility lift policy. F 684, RCA determined the facility failed to assess Resident #1 for four hours knowing there was blood on the floor, bandages not intact and saturated with blood, did not reassess after reporting the blood with resident on anticoagulant. RCA determined additional needs for education to all staff on notifying nurse of change in condition. RCA determined LPN #1 did not reassess for active bleeding and address the care related to resident on anticoagulant therapy and was educated by RN #1 on 02/22/2023 at 2:30 PM on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy. F 656, RCA determined the facility failed to properly follow Resident #2's care plan for a full body lift with two staff members to prevent the likelihood of a serious outcome by having resident dangling midair in the lift out in the hallway with no other staff members around. RCA determined Certified Nursing Assistant (CNA) #1 failed to follow facility policy and procedure related to care plan and received a corrective termination action on 02/23/2023 at 12:30 PM. F 686, RCA determined the facility failed to provide routine and consistent wound care,	M 615		

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M 615	Continued From page 29 wound assessments, and wound documentation put Resident #4, Resident #5, Resident #6, and Resident #7 and all other residents who are at risk for skin breakdown at risk for serious harm, serious injury, serious impairment, or possible death. The facilities failure to implement care plan interventions related to wound care put Resident #4, Resident #5, Resident #6, and Resident #7 and all other residents who are at risk for skin breakdown at risk for serious harm, serious injury, serious impairment, or possible death. RCA determined the facility failed to have proper documentation and assessment of wounds, designated wound care nurse, complete admission body audit. RCA determined facility failed to implement new interventions related to wounds. Facility did hire new Licensed Practical Nurse three (3) weeks ago. Assessment On 2/22/23 at 1:30 PM Registered Nurse Treatment Nurse assessed Resident #1 right lateral foot with findings of a skin flap. Resident #1's bandages were changed and treatment completed following physician orders on 02/22/2023 by RN Treatment Nurse. On 02/22/2023 at 2:10 PM, Resident #1 was assessed by RN #1 for active bleeding and addressed the care related to resident on anticoagulant therapy. On 02/23/2023 at 2:10 PM, Resident #2 was assessed and a body audit was completed by RN #2 with no negative outcomes. On 02/23/2023 at 2:15 PM, a total of twenty-nine (29) residents were identified on anticoagulant therapy by RN #1. Resident assessments were	M 615		

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M 615	Continued From page 30 completed by RN #2, RN #3, and RN #4 for any active or new change in conditions for residents on anticoagulant therapy. No residents at risk identified. On 2/23/2023, Maintenance Director completed audit of all beds for functionality. 124 beds were checked with two (2) identified with motor not working and no issues with footboard not fitting properly. Both beds identified with motor not working were replaced. On 2/23/2023, RN#10, completed Transfer / Mobility Status Criteria for forty-nine (49) residents identified as needing full body lift transfer. On 3/02/23 at 10:00 AM, Resident #4, Resident #5, and Resident #6 are currently not in the center and unable to be assessed. Resident #4, Resident #5, and Resident #6 did not have assessments completed related to a skin audit prior to leaving the center and are still out of the center as of 03/03/2023. On 3/02/2023, RN#10 and LPN#2 reviewed Care Plans for seventeen (17) resident with skin concerns and sixty-one (61) residents at risk for skin concerns per the Braden Scale. Three (3) Care Plans were updated for residents with skin concerns. On 3/2/2023, RN#1 completed Wound - Weekly Observation Tools for seventeen (17) residents with a total of thirty-five (35) wounds. Education On 02/22/2023 at 2:30 PM, RN #1 initiated education to LPN #1 on Anticoagulant Therapy	M 615		

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M 615	Continued From page 31 related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy. On 02/23/2023 at 2:20 PM, RN #1 initiated education to licensed nurses to properly assess residents for active bleeding and address the care for adverse outcomes related to residents on anticoagulant therapy. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 02/23/2023 at 2:25 PM, RN #1 initiated education to all staff to notify a nurse if blood is observed, bandage noted with blood, and bandage not intact to properly address the resident care for adverse outcomes. No current staff or newly hired staff will work without the aforementioned education. On 02/23/2023 at 2:25 PM, RN #1 initiated education to nursing staff ensuring to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 02/23/2023 at 2:30 PM, the ED/RN #1 initiated education to all staff regarding notification and identification of improper working bed with foot board fitting the bed to prevent injuries. No current staff or newly hired staff will work without the aforementioned education. On 2/23/2023 at 2:30, RN #1 initiated education on mechanical lift transfers and the need for two (2) staff members to assistance. No current nursing staff or newly hired nursing staff will work without the aforementioned education.	M 615			

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M 615	Continued From page 32 On 03/02/2023 at 6:00 PM, the ED/RN #1 initiated education to all nurses regarding wound identification and treatment to include, admission/readmission body audit, completing Braden scale assessment, notifying provider for treatment if wound is identified, completing treatment as ordered if treatment nurse is not available, ensure documentation is completed on electronic treatment administration record (eTAR), and completing weekly skin checks. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 03/02/2023 at 6:05 PM, the ED/RN #1 initiated education with Certified Nurse Assistants (CNAs) regarding nurse notification if a skin concern is identified and following chain of command if nurse is unavailable. No current CNA or newly hired CNA will work without the aforementioned education. On 3/02/2023 at 6:10 PM, education with MDS RN and MDS LPN was initiated by the ED/RN #1 to ensure comprehensive care plan interventions are implemented for residents with current pressure ulcer wounds and resident who are at risk for skin breakdown. No current MDS licensed nurses or newly hired MDS licensed nurses will work without the aforementioned education. Corrective Action On 02/23/2023 at 12:30 PM, CNA #1, was removed from floor and corrective termination action by RN #1 related to not following facility policy and procedures related to not properly following Resident #2's care plan for a full body	M 615		

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M 615	Continued From page 33 lift with two staff members. On 2/22/23 at 2:00 PM, the Maintenance Assistant changed out Resident #1's bed to ensure the resident was in a working bed to prevent a hazard to the resident's feet. Quality rounds were performed on 02/23/2023 beginning at 2:15 PM by the Maintenance Director and Maintenance Assistant to ensure beds working properly and foot boards are properly fitting the bed. 124 beds were checked with two (2) beds identified with motor not working and no issue with foot board not fitting properly. Both beds replaced with properly working bed. On 02/23/2023 at 2:20 PM, Minimum Data Set (MDS) Nurse completed a Quality Review of current residents to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/01/2023 at 11:30 AM, RN #7 completed skin audit on Resident #7 with no new findings. Beginning on 2/23/2023 body audits initiated and completed on 3/02/2023 by 9:00 PM, by RN #2, RN #3, RN #4, RN #5, RN #6, RN #7, RN #8, and LPN #1, for current in house residents on census to determine stages of wounds. LPN #1 observed residents without identified skin concerns with instructions to notify RN if skin concerns identified. Results of the body audit identified an additional 3 residents with four (4) new wounds. RN #8 updated CNA Task in the electronic medical record with turning and repositioning for current residents so CNAs can document turning and repositioning.	M 615		

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M 615	Continued From page 34 RN #10 and LPN #2 reviewed care plans to ensure interventions are implemented for seventeen (17) residents with current pressure ulcers and sixty-one (61) residents who are at risk for skin breakdown. RN # 1 reviewed treatment orders to ensure appropriate treatment. RN #10 and LPN #2 completed Braden scale on current in house residents. RN #1 completed wound assessment for current in house residents with identified wounds. The State Agency (SA) validated the facility's Removal plan on 03/6/23. Quality Assessment: On 3/6/23, the SA validated through record review of the meeting sign in sheet and through staff interviews that the facility held a Quality Assurance Performance Improvement (QAPI) Committee meeting on 2/21/23. On 3/6/23, the SA validated through record review of the meeting sign in sheet and through staff interviews that the facility held a QAPI meeting on 2/23/2023 regarding care plans, anticoagulant therapy and assessments, mechanical lifts, maintenance requests related to equipment that doesn't work or does not fit the resident appropriately. On 3/6/2023, the SA validated through record review of sign in sheets and staff interviews, the facility had a QAPI meeting on 3/2/23 regarding wound care including treatments, documentation, prevention, and assessments. Assessment	M 615		

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M 615	Continued From page 35 On 3/6/23, the SA validated through record review and interviews that RN # 11 assessed the right lateral foot with findings of a skin flap for Resident #1 and completed the treatment per Physician Orders on 2/22/23. On 3/6/23, the SA validated through staff interview and record review that Resident #1 was assessed by RN #1 for active bleeding on 2/22/23. On 3/6/23, the SA validated through record review that Resident #2 was assessed, and a body audit was completed on 2/23/23. On 3/6/23, the SA validated through record review and staff interview that on 2/23/2023, residents identified on anticoagulant therapy were assessed. On 3/6/23, the SA validated through staff interview all beds were checked for functionality and footboard issues on 2/23/23. On 3/6/23, the SA validated through record review that on 2/23/2023, the facility audited and identified residents identified that required a full body lift transfer. On 3/6/23, the SA validated through staff interviews and record review that the facility reviewed care plans for residents with skin concerns. On 3/6/23, the SA validated through staff interview and record review that the facility completed Wound - Weekly Observation Tools for residents with wounds. Education	M 615			

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M 615	Continued From page 36 On 3/6/23, the SA validated through staff interview and record review that the facility educated LPN #1 on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy on 2/22/23. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 2/23/23 to licensed nurses to properly assess residents for active bleeding and address the care for adverse outcomes related to residents on anticoagulant therapy. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 02/23/2023 to all staff to notify a nurse if blood is observed, bandage noted with blood, and bandage not intact to properly address the resident care for adverse outcomes. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 02/23/2023 to nursing staff ensuring to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 02/23/2023 to all staff regarding notification and identification of improper working bed with foot board fitting the bed to prevent injuries. On 3/6/23, the SA validated through staff interview and record review, the facility provided education on 2/23/2023 regarding mechanical lift transfers and the need for two (2) staff members	M 615		

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M 615	Continued From page 37 to assistance. On 3/6/23, the SA validated through staff interview and record review, the facility provided education on 03/02/2023 all nurses regarding wound identification and treatment to include, admission/readmission body audit, completing Braden scale assessment, notifying provider for treatment if wound is identified, completing treatment as ordered if treatment nurse is not available, ensure documentation is completed on electronic treatment administration record (eTAR), and completing weekly skin checks. On 3/6/23, the SA validated through staff interview and record review that on 03/02/2023 the facility provided education with Certified Nurse Assistants (CNAs) regarding nurse notification if a skin concern is identified and following chain of command if nurse is unavailable. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 3/02/2023 to the MDS RN and MDS LPN regarding ensuring the comprehensive care plan interventions are implemented for residents with current pressure ulcer wounds and resident who are at risk for skin breakdown. On 3/6/23, the SA validated through staff interview and record review that on 02/23/2023 CNA #1 received corrective termination action related to not following facility policy and procedures related to not properly following Resident #2's care plan for a full body lift with two staff members. On 3/6/23, the SA validated through observation and interview that on 2/22/23, the Maintenance	M 615		

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M 615	Continued From page 38 Assistant changed out Resident #1's bed to ensure the resident was in a working bed to prevent a hazard to the resident's feet. On 3/6/23, the SA validated through observation and staff interview that on 02/23/2023, the Maintenance Director and Maintenance Assistant rounded on resident rooms to ensure beds working properly and foot boards are properly fitting the bed. On 3/6/23, the SA validated through staff interview that on 02/23/2023, the MDS Nurse completed a review of current residents to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/6/23, the SA validated through record review that on 3/01/2023, Resident #7 had a skin audit completed. On 3/6/23, the SA validated through record review and staff interviews that body audits were completed on 3/02/2023 for current in-house residents on census to determine stages of wounds, the CNA Tasks were updated in the electronic medical record with turning and repositioning for current residents so CNAs can document turning and repositioning, care plans were reviewed care plans to ensure interventions are implemented, treatment orders were reviewed to ensure appropriate treatment, Risk assessments (Braden scale) was completed, and wound assessments were completed for current in house residents with identified wounds.	M 615			
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the	M 640			3/28/23

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M 640	Continued From page 39 residents' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that the residents' environment remained free from actual harm for Resident #1 and the likelihood for harm for Resident #2 for two (2) of five (5) sampled residents, as evidenced by the facility's failure to identify an inoperable mechanical bed with an improperly fitting footboard that resulted in a flap laceration to Resident #1's right lateral foot and failure to prevent the likelihood of injury when the State Agency (SA) observed Certified Nurse Aide (CNA) #1 using a full body mechanical lift with Resident #2 suspended mid-air in a sling, without required two (2) person assistance. The facility's failure to ensure that the residents' environment remained free from accidents/hazards placed these residents and other residents, in a situation that was likely to cause serious harm, injury, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 2/22/23 when Resident #1 was observed with his right foot wedged between the mechanical bed's footboard and the mattress and Resident #2 was suspended in mid-air. The facility Administrator was notified of the IJ on 2/23/23 at 1:45 PM and provided an IJ Template. The facility provided an	M 640	* On 2-22-23 at 1:30pm Registered Nurse (RN) Treatment Nurse assessed Resident #1 right lateral foot with findings of a skin flap. Resident #1 bandages were changed and treatment completed following physician orders on 2-22-23 by RN Treatment Nurse at 1:30pm. On 2-22-23pm at 2:00pm, the Maintenance Assistant changed out Resident #1's bed to ensure the resident was in a working bed to prevent a hazard to the residents feet. On 2-23-23 at 12:30pm, Certified Nursing Assistant (CNA) #1 was removed from floor and corrective termination action by RN #1 related to not following facility policy and procedures related to not properly following Resident #2's care plan for a full body lift with two staff members. Quality Rounds were performed on 2-23-23 beginning at 2:15pm by Maintenance Director and Maintenance Assistant to ensure beds working properly and foot boards are properly fitting the beds. 124 beds were checked with two (2) beds identified with motor not working and no issue with foot boards not fitting properly. Both beds replaced with	

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M 640	Continued From page 40 acceptable Removal Plan on 2/24/23, in which they alleged all corrective actions to remove the IJ were completed and the IJ removed on 2/24/23. The SA validated the Removal Plan on 2/27/23 and determined the IJ was removed on 2/24/23, prior to exit. Due to additional identification of IJ, the SA notified the Administrator that the IJ Template dated 2/23/23 and the Removal Plan dated 2/24/23 were being rescinded. The facility Administrator was notified of the IJ and presented a revised IJ Template on 3/2/23 at 5:10 PM. The facility provided an acceptable Removal Plan on 3/4/23, in which they alleged all corrective action to remove the IJ were completed and the IJ removed on 3/3/23. The SA validated the Removal Plan on 3/6/23 and determined the IJ was removed on 3/3/23, prior to exit. Therefore, the scope and severity for Rule Accidents was lowered from a "K" to an "E", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Maintenance", dated 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 ...All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported	M 640	properly working beds. On 2-23-23, RN #10 completed Transfer / Mobility Status Criteria for forty-nine (49) residents identified as needing full body lift transfer. * All residents have the potential to be affected. *Beginning 2-23-23 at 2:30pm and ending 3-2-23, RN #1 initiated education to nursing staff on mechanical lift transfers and the need for two (2) staff members to assist. No current nursing staff or newly hired nursing staff will work without the aforementioned education. Beginning 2-23-23 at 6:00pm and ending 3-2-23, Executive Director (ED) / RN #1 initiated education to all staff regarding notification and identification of improper working bed with foot board fitting the bed to prevent injuries and Facility Policy Maintenance. No current staff or newly hired staff will work without the aforementioned education. On 2-23-23, at 2:00pm, an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee met to conduct Root Cause Analysis (RCA) and create Removal Plan for Immediate Jeopardy received regarding F 689 Accidents / Supervision. On 3-2-23, at 5:30pm, the QAPI Committee met to revise the Performance Improvement Plan for AD Hoc QAPI meeting dated 2-23-23 to conduct RCA and to create Removal Plan for Immediate	

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M 640	Continued From page 41 to maintenance using the Maintenance Repair Request form ..." A review of the facility's policy, "Transfer/Mobility Evaluation Low Lift", revised 11/1/2019, revealed, " ...Procedure ...3. Two staff members are required when using a mechanical lift ..." A review of the "User Manual" for the mechanical lift revealed, " ...Warning ...recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures ..." Resident #1 At 12:20 PM on 02/22/23, during an interview and observation, Resident #1 was lying in bed, the mattress was approximately 12 inches shorter than the footboard, and the resident's right foot was in the gap, wedged between the footboard and the bed frame. There was an area of dried blood on the side of the bed that was approximately the size of a golf ball. He explained that not only did his footboard not fit appropriately, but his mechanical bed was broken, and he could not raise or lower the bed; it would only lie flat. On 02/22/23 at 1:00 PM, during an interview and observation of Resident #1 with Registered Nurse (RN) #11, she confirmed that the bed looks "faulty", and the resident's right foot was observed between the bed frame and the footboard. On 2/22/23 at 1:15 PM, in an interview and observation of Resident #1 with CNA #1, she confirmed that his right foot was under the foot board of the bed between the bed frame and the	M 640	Jeopardies received regarding F689 Accidents / Supervision. Policies and Procedures reviewed: Skin and Wound Guidelines, Plan of Care, Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in Condition which required not changes. Reviewed Policy and Procedure Maintenance with changes made in the notification procedure to implement maintenance repair request form. *Facility will ensure proper identification of a working bed to prevent any adverse effects to a resident and ensure a full body lift is used with two staff members to prevent any adverse effects to a resident requiring the use of a full body lift. The ED will make observation rounds for five (5) residents five (5) times per week for two (2) weeks and then three (3) residents monthly for three (3) months beginning 2-27-23. Findings will be brought to the QAPI Committee Meeting by Executive Director on March 28, 2023 to discuss finding and make necessary changes as indicated, then monthly times three months.	

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M 640	Continued From page 42 foot board and stated, "the mattress does not fit the bed". She said that the bed had been broken for months and that it did not have any hand cranks to manually raise or lower the bed or a remote control to do it electronically. She said that Maintenance and Administration had been notified verbally of the broken bed because it is easier to tell them during the day. She stated that there are "slips" to fill out when something needs to be repaired by Maintenance. A review of the facility's maintenance repair request form revealed there were no written requests to repair Resident #1's bed. In an observation and interview with RN #11 on 02/22/23 at 1:30 PM, she assessed Resident #1's right foot and stated he had a "laceration flap" to the lateral side that measured 5.5 centimeters (cm) x 3.0 cm. There was a large amount of dried blood noted around the laceration and down the lateral side of the right foot. She confirmed it was a flap laceration and not a diabetic wound and the laceration could have been caused by the faulty bed or the footboard. She explained that this was the first time she had seen Resident #1 and his bed, but it was "obvious the mattress does not fit the bed, and anyone should have seen the faulty bed." During an interview with Resident #1 on 02/22/23 at 1:50 PM, he explained he had cut his foot on the bed frame or the footboard, but he was unable to recall exactly when because he cannot feel his feet very much and he cannot tell if his feet are hurting. A record review of "Wound-Weekly Observation Tool" for Resident #1, dated 02/22/23, identified the wound location as "Right Lateral Foot" and	M 640		

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M 640	Continued From page 43 the wound type as "Skin flap". On 02/22/23 at 03:40 PM, during an interview with CNA #16, she explained when equipment needs to be repaired, she completes a request form and gives it to Maintenance. She explained Resident #1's bed had been broken since Thanksgiving and Administration and Maintenance had been made aware. She denied completing the request form but stated she had verbally told Maintenance and Administration. On 02/22/23 at 04:15 PM, during an interview with the Maintenance Director, he reported there were no repair request forms for Resident #1's bed. He explained about two weeks ago, he had been told that the bed was broken and needed a new remote. He said he had told his staff that he needed to know when a remote is broken because Resident #1's bed is a rental and is not like the other beds in the facility. On 02/23/23 at 09:40 AM, during an interview with the Assistant Director of Nursing (ADON), he explained he did know Resident #1's bed was broken. On 02/23/23 at 09:55 AM, during an interview with the Administrator, she stated that she walks throughout the building and that she was not advised until yesterday (02/22/23) that Resident #1's bed was not working properly. She was also not aware of any changes to the mattress or bed. She said that she expected her staff to provide care to the residents and if a hazard is identified in a resident's room, she would expect the staff to notify Maintenance or herself immediately. On 02/23/23 at 11:20 AM during an interview with Licensed Practical Nurse (LPN) #3, she stated	M 640		

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M 640	Continued From page 44 that Resident #1's bed had been in that condition for a long time, with the bed not working and the mattress not fitting the bed. She said that she gave a verbal report to the Maintenance Department but was unable to recall how long ago that had been. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 11/01/2020 with diagnoses including Paroxysmal Atrial Fibrillation, Chronic Embolism and Thrombosis of Other Specified Veins, and Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Resident #2 On 02/23/23 at 11:50 AM, during an observation, CNA #1 was operating a mechanical lift in the hallway with Resident #2 in a full body sling suspended midair. CNA #1 was operating the lift without assistance from another staff member. The resident's wheelchair was noted to be approximately five (5) feet away from the CNA and lift. LPN #9 was at her medication cart approximately five (5) doors away for the resident's door and went over to assist and complete the transfer. At 11:55 AM on 02/23/23, during an interview, LPN #9, she explained she was passing medications and observed CNA #1 using the mechanical lift while out in the hallway with Resident #2 in a sling and his wheelchair far away from the lift. She stated she was unsure of	M 640		

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M 640	Continued From page 45 why the CNA was transferring the resident in the hallway. She said that two (2) staff members must be present at all times when using a mechanical lift and that staff has received training on this. She said the CNA could have dropped the resident from the lift or the resident could have hit his head and caused serious damage. At 12:05 PM on 02/23/23, in an interview with CNA #1, she explained that Resident #2 assists her with transfers by holding on to the locked wheelchair when she lowers him into the chair from the mechanical lift. She confirmed she was operating a mechanical lift by herself. She explained that she had begun the transfer in the resident's room, took the wheelchair out into the hallway, and then transferred resident. She reported there was no one to help her and she had planned on using the mechanical lift to transfer other residents by herself, but she "wasn't now since I'm being watched". She reported she had been trained to work independently. At 1:45 PM on 02/23/23, during an interview with the Administrator, RN #1, and RN #5, the Administrator stated that they all had heard about the CNA transferring the resident with a mechanical lift in the hallway alone. She said she expected staff to have two (2) staff members at all times when using a mechanical lift and all nursing staff had previously been trained. She stated that CNA #1 had been educated and given a return demonstration on using the lift. On 2/23/23 at 2:50 PM, during an interview with Resident #2, he stated that CNA #1 had transferred him by herself before and he helped her by using the arms of the wheelchair. He stated that everyone else transfers him with two	M 640		

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M 640	Continued From page 46 people assisting. At 03:15 PM on 02/23/23, during an interview with the Director of Nursing (DON), she explained that when a mechanical lift is in use, two (2) staff members should be present at all times for a transfer and she had informed her staff to come get her if no one else is available. A record review of the "Admission Record" revealed the facility admitted Resident #2 on 9/20/2013 and he had diagnoses including Diabetes Mellitus and Unspecified Dementia. A record review of the MDS with an ARD of 11/16/22, revealed Resident #2 had a BIMS score of 13 which indicated he was cognitively intact. A record review of the "Order Summary Report" with "Active Orders As Of: 02/23/2023", revealed Resident #2 had a Physician's Order dated 6/28/22 for "Hoyer lift to be used for transfer". A record review of the "Orientation In-Service Acknowledgement" revealed CNA #1 received training on resident handling on 12/16/21. A record review of an "In-Service Sign-In Sheet" dated 12/8/22 revealed CNA #1 attended a training on 12/8/22 related to Hoyer Lift Training. The facility submitted the following acceptable Removal Plan on 03/4/23: Quality Assessment: On 2/21/2023, at 10:00am, an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee met to review / develop / implement wound care program. Attendees were Executive	M 640		

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M 640	Continued From page 47 Director (ED), Director of Nursing (DON), Maintenance Director, Director of Rehabilitation (DOR), Assistant Director of Nursing / Infection Control Preventionist (ADON / ICP), Business Office Manager (BOM), Human Resources Director (HRD), Medical Director (MD) attended by phone. A review of policy and procedures were: Skin and Wound Guidelines. Areas discussed: Reeducation of staff regarding wound management / treatment, reeducation of staff on wound identification, reeducate nursing staff on wound documentation to include Licensed Nurse Weekly Skin Integrity form, completing Weekly Wound Observation Tool, completing and documenting body audit on admission / readmission, one hundred (100) percent skin audits to ensure all wound are identified and treatment in place, reeducate certified nursing assistant on notifying nurse if skin concern is identified. On 2/23/2023, at 2:00pm, an Ad Hoc QAPI Committee met to conduct Root Cause Analysis (RCA) and create Removal Plan for Immediate Jeopardies received regarding F 656 -Develop / Implement Comprehensive Care Plan, F 684 Quality of Care and F 689 - Accidents / Supervision. Attendees were ED, DON, Maintenance Director, DOR, ADON / ICP, BOM, HRD, MD attended by phone. A review of policy and procedures were: Care Plan, Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in condition which required no changes. Reviewed policy and procedure "Maintenance" with changes made in the notification procedure to implement maintenance repair request form. Topics discussed include: reeducate all staff on notification to Maintenance or Administrator when bed not working properly, Maintenance director to	M 640		

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NAME OF PROVIDER OR SUPPLIER COASTAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 BROAD AVE GULFPORT, MS 39501		
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M 640	Continued From page 48 check all beds to ensure working properly, all staff to notify nurse if blood is observed, bandage noted with blood, bandage not intact and nurse to properly assess resident for adverse reactions, Licensed Nurses to assess residents for active bleeding and address any adverse outcomes for residents on anticoagulant therapy, reeducate nursing staff for transferring resident in full body lift, reeducate nursing staff to follow care plan that reflects specific resident needs related to full body lifts, review and revise if indicated residents transfer / mobility status, review and revise if indicated eMAR for assessing resident for signs and symptoms regarding anticoagulant therapy. F 689, RCA determined the facility failed to properly identify an improper working bed with foot board not properly fitting bed due to staff failure of notification and additional need for education. All staff need additional training on how to report beds not properly working. RCA determined the facility failed to prevent possibility of injury by using full body sling with only one staff member, due to certified nurse assistant #1 failure to follow facility lift policy. F 684, RCA determined the facility failed to assess Resident #1 for four hours knowing there was blood on the floor, bandages not intact and saturated with blood, did not reassess after reporting the blood with resident on anticoagulant. RCA determined additional needs for education to all staff on notifying nurse of change in condition. RCA determined LPN #1 did not reassess for active bleeding and address the care related to resident on anticoagulant therapy and was educated by RN #1 on 02/22/2023 at 2:30 PM on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy.	M 640		

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M 640	Continued From page 49 F 656, RCA determined the facility failed to properly follow Resident #2's care plan for a full body lift with two staff members to prevent the likelihood of a serious outcome by having resident dangling midair in the lift out in the hallway with no other staff members around. RCA determined Certified Nursing Assistant (CNA) #1 failed to follow facility policy and procedure related to care plan and received a corrective termination action on 02/23/2023 at 12:30 PM. On 3/2/2023, at 5:30pm, the QAPI Committee met to revise Performance Improvement Plan for Ad Hoc QAPI Meeting dated February 21, 2023 conduct Root Cause Analysis (RCA) and to create Removal Plan for Immediate Jeopardies F 686 Treatment / Services to Prevent / Heal Pressure Ulcers, F 684 Quality of Care and F 689 - Accidents / Supervision and F 656 Development / Implement Comprehensive Care Plan. Attendees were: MD, ED, DON, Regional Director of Clinical Services (RDCS), ICP, BOM, Medical Records Licensed Practical Nurse (LPN), Minimum Data Set Registered Nurse, Minimum Data Set Licensed Practical Nurse, Certified Nursing Assistant (CNA). Policies and Procedures reviewed: Skin and Wound Guidelines, Plan of Care. Transfer / Mobility Evaluation Low Lift, Anticoagulant Therapy, Notification of Change in condition which required no changes. Reviewed policy and procedure "Maintenance" with changes made in the notification procedure to implement maintenance repair request form. Areas discussed included: Continue education of staff regarding wound management / treatment, continue licensed nurse to complete admission / readmission body audit, completing Braden Scale assessment, notifying provider for treatment if new wound is identified, notifying resident representative if new	M 640		

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M 640	Continued From page 50 wound or change in wound is identified, completing treatments if wound care nurse is not available, completing weekly Skin Integrity Review on residents, completing Wound Weekly Observation Tool on wounds, review and update Wound Care Plan as indicated for residents with current wounds or potential risk, review and update wound orders as indicated, reeducate certified nursing assistants regarding notification to nurse if skin concern is identified, review and revise if indicated schedule for Licensed Nurse Weekly Skin Integrity Review and update certified nursing assistant task for residents to include Turning and Repositioning every two (2) hours on residents with pressure ulcers and / or at risk for pressure ulcers. F 689, RCA determined the facility failed to properly identify an improper working bed with foot board not properly fitting bed due to staff failure of notification and additional need for education. All staff need additional training on how to report beds not properly working. RCA determined the facility failed to prevent possibility of injury by using full body sling with only one staff member, due to certified nurse assistant #1 failure to follow facility lift policy. F 684, RCA determined the facility failed to assess Resident #1 for four hours knowing there was blood on the floor, bandages not intact and saturated with blood, did not reassess after reporting the blood with resident on anticoagulant. RCA determined additional needs for education to all staff on notifying nurse of change in condition. RCA determined LPN #1 did not reassess for active bleeding and address the care related to resident on anticoagulant therapy and was educated by RN #1 on 02/22/2023 at 2:30 PM on Anticoagulant Therapy related to reassessing for	M 640		

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M 640	Continued From page 51 active bleeding and addressing the care related to resident on anticoagulant therapy. F 656, RCA determined the facility failed to properly follow Resident #2's care plan for a full body lift with two staff members to prevent the likelihood of a serious outcome by having resident dangling midair in the lift out in the hallway with no other staff members around. RCA determined Certified Nursing Assistant (CNA) #1 failed to follow facility policy and procedure related to care plan and received a corrective termination action on 02/23/2023 at 12:30 PM. F 686, RCA determined the facility failed to provide routine and consistent wound care, wound assessments, and wound documentation put Resident #4, Resident #5, Resident #6, and Resident #7 and all other residents who are at risk for skin breakdown at risk for serious harm, serious injury, serious impairment, or possible death. The facilities failure to implement care plan interventions related to wound care put Resident #4, Resident #5, Resident #6, and Resident #7 and all other residents who are at risk for skin breakdown at risk for serious harm, serious injury, serious impairment, or possible death. RCA determined the facility failed to have proper documentation and assessment of wounds, designated wound care nurse, complete admission body audit. RCA determined facility failed to implement new interventions related to wounds. Facility did hire new Licensed Practical Nurse three (3) weeks ago. Assessment On 2/22/23 at 1:30 PM Registered Nurse Treatment Nurse assessed Resident #1 right lateral foot with findings of a skin flap. Resident	M 640		

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M 640	Continued From page 52 #1's bandages were changed and treatment completed following physician orders on 02/22/2023 by RN Treatment Nurse. On 02/22/2023 at 2:10 PM, Resident #1 was assessed by RN #1 for active bleeding and addressed the care related to resident on anticoagulant therapy. On 02/23/2023 at 2:10 PM, Resident #2 was assessed and a body audit was completed by RN #2 with no negative outcomes. On 02/23/2023 at 2:15 PM, a total of twenty-nine (29) residents were identified on anticoagulant therapy by RN #1. Resident assessments were completed by RN #2, RN #3, and RN #4 for any active or new change in conditions for residents on anticoagulant therapy. No residents at risk identified. On 2/23/2023, Maintenance Director completed audit of all beds for functionality. 124 beds were checked with two (2) identified with motor not working and no issues with footboard not fitting properly. Both beds identified with motor not working were replaced. On 2/23/2023, RN#10, completed Transfer / Mobility Status Criteria for forty-nine (49) residents identified as needing full body lift transfer. On 3/02/23 at 10:00 AM, Resident #4, Resident #5, and Resident #6 are currently not in the center and unable to be assessed. Resident #4, Resident #5, and Resident #6 did not have assessments completed related to a skin audit prior to leaving the center and are still out of the center as of 03/03/2023.	M 640		

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M 640	Continued From page 53 On 3/02/2023, RN#10 and LPN#2 reviewed Care Plans for seventeen (17) resident with skin concerns and sixty-one (61) residents at risk for skin concerns per the Braden Scale. Three (3) Care Plans were updated for residents with skin concerns. On 3/2/2023, RN#1 completed Wound - Weekly Observation Tools for seventeen (17) residents with a total of thirty-five (35) wounds. Education On 02/22/2023 at 2:30 PM, RN #1 initiated education to LPN #1 on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy. On 02/23/2023 at 2:20 PM, RN #1 initiated education to licensed nurses to properly assess residents for active bleeding and address the care for adverse outcomes related to residents on anticoagulant therapy. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 02/23/2023 at 2:25 PM, RN #1 initiated education to all staff to notify a nurse if blood is observed, bandage noted with blood, and bandage not intact to properly address the resident care for adverse outcomes. No current staff or newly hired staff will work without the aforementioned education. On 02/23/2023 at 2:25 PM, RN #1 initiated education to nursing staff ensuring to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. No	M 640		

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M 640	Continued From page 54 current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 02/23/2023 at 2:30 PM, the ED/RN #1 initiated education to all staff regarding notification and identification of improper working bed with foot board fitting the bed to prevent injuries. No current staff or newly hired staff will work without the aforementioned education. On 2/23/2023 at 2:30, RN #1 initiated education on mechanical lift transfers and the need for two (2) staff members to assistance. No current nursing staff or newly hired nursing staff will work without the aforementioned education. On 03/02/2023 at 6:00 PM, the ED/RN #1 initiated education to all nurses regarding wound identification and treatment to include, admission/readmission body audit, completing Braden scale assessment, notifying provider for treatment if wound is identified, completing treatment as ordered if treatment nurse is not available, ensure documentation is completed on electronic treatment administration record (eTAR), and completing weekly skin checks. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On 03/02/2023 at 6:05 PM, the ED/RN #1 initiated education with Certified Nurse Assistants (CNAs) regarding nurse notification if a skin concern is identified and following chain of command if nurse is unavailable. No current CNA or newly hired CNA will work without the aforementioned education. On 3/02/2023 at 6:10 PM, education with MDS	M 640			

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M 640	Continued From page 55 RN and MDS LPN was initiated by the ED/RN #1 to ensure comprehensive care plan interventions are implemented for residents with current pressure ulcer wounds and resident who are at risk for skin breakdown. No current MDS licensed nurses or newly hired MDS licensed nurses will work without the aforementioned education. Corrective Action On 02/23/2023 at 12:30 PM, CNA #1, was removed from floor and corrective termination action by RN #1 related to not following facility policy and procedures related to not properly following Resident #2's care plan for a full body lift with two staff members. On 2/22/23 at 2:00 PM, the Maintenance Assistant changed out Resident #1's bed to ensure the resident was in a working bed to prevent a hazard to the resident's feet. Quality rounds were performed on 02/23/2023 beginning at 2:15 PM by the Maintenance Director and Maintenance Assistant to ensure beds working properly and foot boards are properly fitting the bed. 124 beds were checked with two (2) beds identified with motor not working and no issue with foot board not fitting properly. Both beds replaced with properly working bed. On 02/23/2023 at 2:20 PM, Minimum Data Set (MDS) Nurse completed a Quality Review of current residents to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/01/2023 at 11:30 AM, RN #7 completed skin	M 640		

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M 640	Continued From page 56 audit on Resident #7 with no new findings. Beginning on 2/23/2023 body audits initiated and completed on 3/02/2023 by 9:00 PM, by RN #2, RN #3, RN #4, RN #5, RN #6, RN #7, RN #8, and LPN #1, for current in house residents on census to determine stages of wounds. LPN #1 observed residents without identified skin concerns with instructions to notify RN if skin concerns identified. Results of the body audit identified an additional 3 residents with four (4) new wounds. RN #8 updated CNA Task in the electronic medical record with turning and repositioning for current residents so CNAs can document turning and repositioning. RN #10 and LPN #2 reviewed care plans to ensure interventions are implemented for seventeen (17) residents with current pressure ulcers and sixty-one (61) residents who are at risk for skin breakdown. RN # 1 reviewed treatment orders to ensure appropriate treatment. RN #10 and LPN #2 completed Braden scale on current in house residents. RN #1 completed wound assessment for current in house residents with identified wounds. The State Agency (SA) validated the facility's Removal plan on 03/6/23. Quality Assessment: On 3/6/23, the SA validated through record review of the meeting sign in sheet and through staff interviews that the facility held a Quality Assurance Performance Improvement (QAPI) Committee meeting on 2/21/23. On 3/6/23, the SA validated through record review	M 640		

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M 640	Continued From page 57 of the meeting sign in sheet and through staff interviews that the facility held a QAPI meeting on 2/23/2023 regarding care plans, anticoagulant therapy and assessments, mechanical lifts, maintenance requests related to equipment that doesn't work or does not fit the resident appropriately. On 3/6/2023, the SA validated through record review of sign in sheets and staff interviews, the facility had a QAPI meeting on 3/2/23 regarding wound care including treatments, documentation, prevention, and assessments. Assessment On 3/6/23, the SA validated through record review and interviews that RN # 11 assessed the right lateral foot with findings of a skin flap for Resident #1 and completed the treatment per Physician Orders on 2/22/23. On 3/6/23, the SA validated through staff interview and record review that Resident #1 was assessed by RN #1 for active bleeding on 2/22/23. On 3/6/23, the SA validated through record review that Resident #2 was assessed, and a body audit was completed on 2/23/23. On 3/6/23, the SA validated through record review and staff interview that on 2/23/2023, residents identified on anticoagulant therapy were assessed. On 3/6/23, the SA validated through staff interview all beds were checked for functionality and footboard issues on 2/23/23.	M 640		

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M 640	Continued From page 58 On 3/6/23, the SA validated through record review that on 2/23/2023, the facility audited and identified residents identified that required a full body lift transfer. On 3/6/23, the SA validated through staff interviews and record review that the facility reviewed care plans for residents with skin concerns. On 3/6/23, the SA validated through staff interview and record review that the facility completed Wound - Weekly Observation Tools for residents with wounds. Education On 3/6/23, the SA validated through staff interview and record review that the facility educated LPN #1 on Anticoagulant Therapy related to reassessing for active bleeding and addressing the care related to resident on anticoagulant therapy on 2/22/23. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 2/23/23 to licensed nurses to properly assess residents for active bleeding and address the care for adverse outcomes related to residents on anticoagulant therapy. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 02/23/2023 to all staff to notify a nurse if blood is observed, bandage noted with blood, and bandage not intact to properly address the resident care for adverse outcomes. On 3/6/23, the SA validated through staff interview and record review that the facility	M 640		

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M 640	Continued From page 59 provided education on 02/23/2023 to nursing staff ensuring to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 02/23/2023 to all staff regarding notification and identification of improper working bed with foot board fitting the bed to prevent injuries. On 3/6/23, the SA validated through staff interview and record review, the facility provided education on 2/23/2023 regarding mechanical lift transfers and the need for two (2) staff members to assistance. On 3/6/23, the SA validated through staff interview and record review, the facility provided education on 03/02/2023 all nurses regarding wound identification and treatment to include, admission/readmission body audit, completing Braden scale assessment, notifying provider for treatment if wound is identified, completing treatment as ordered if treatment nurse is not available, ensure documentation is completed on electronic treatment administration record (eTAR), and completing weekly skin checks. On 3/6/23, the SA validated through staff interview and record review that on 03/02/2023 the facility provided education with Certified Nurse Assistants (CNAs) regarding nurse notification if a skin concern is identified and following chain of command if nurse is unavailable. On 3/6/23, the SA validated through staff interview and record review that the facility provided education on 3/02/2023 to the MDS RN	M 640			

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M 640	Continued From page 60 and MDS LPN regarding ensuring the comprehensive care plan interventions are implemented for residents with current pressure ulcer wounds and resident who are at risk for skin breakdown. On 3/6/23, the SA validated through staff interview and record review that on 02/23/2023 CNA #1 received corrective termination action related to not following facility policy and procedures related to not properly following Resident #2's care plan for a full body lift with two staff members. On 3/6/23, the SA validated through observation and interview that on 2/22/23, the Maintenance Assistant changed out Resident #1's bed to ensure the resident was in a working bed to prevent a hazard to the resident's feet. On 3/6/23, the SA validated through observation and staff interview that on 02/23/2023, the Maintenance Director and Maintenance Assistant rounded on resident rooms to ensure beds working properly and foot boards are properly fitting the bed. On 3/6/23, the SA validated through staff interview that on 02/23/2023, the MDS Nurse completed a review of current residents to follow the comprehensive care plans to reflect specific resident needs related to full body lifts. On 3/6/23, the SA validated through record review that on 3/01/2023, Resident #7 had a skin audit completed. On 3/6/23, the SA validated through record review and staff interviews that body audits were completed on 3/02/2023 for current in-house	M 640		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24GC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2023
NAME OF PROVIDER OR SUPPLIER COASTAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 BROAD AVE GULFPORT, MS 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) COMPLETE DATE
M 640	Continued From page 61 residents on census to determine stages of wounds, the CNA Tasks were updated in the electronic medical record with turning and repositioning for current residents so CNAs can document turning and repositioning, care plans were reviewed care plans to ensure interventions are implemented, treatment orders were reviewed to ensure appropriate treatment, Risk assessments (Braden scale) was completed, and wound assessments were completed for current in house residents with identified wounds.	M 640		