STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 2/27/23 through 3/2/23. During the survey, the facility was found to not be in compliance with the requirements of participation in Medicare and Medicaid and cited F567, F640, and F645. The facility held a license for 151 beds with a census of 110.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F 567		4/5/23

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

Electronically Signed | 03/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 567	Continued From page 1 exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to ensure a resident had ready and reasonable access to personal funds for one (1) of 24 sampled residents, Resident #68 Findings include: A review of the facility's policy, "(Proper Name of Facility) - Resident Personal Funds", implemented on 2/1/22, revealed the policy did not contain information regarding ready and reasonable access to personal funds for residents. On 02/27/23 at 11:39 AM, in an interview with Resident #68, he stated that he cannot get money from his personal funds on the weekend because the office staff is not at the facility on weekends. On 03/02/23 at 10:42 AM, in an interview with the Administrative Assistant (AA), she stated she is responsible for the residents' personal trust fund	F 567	F567-Protection/Management of Personal Funds CFR(s) 483.10(f)(10)(i)(ii) Resident #68 which was 1 of 24 sampled residents that was identified & interviewed on 2/27/23, at 11:39 AM during the facility survey stated, he cannot get money from his personal funds on the weekend because the office staff is not at the facility on weekends was informed of the Resident Funds Policy by the Administrator on 3/9/2023. There were no adverse findings noted regarding residents with available funds not having access to personal monies. Nursing facility residents with a resident funds account have the potential to be affected by the alleged deficient practice. A Special Resident Council Meeting was held on 3/8/2023, with education provided to current residents on the Resident Fund	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 567	Continued From page 2 accounts. She said that the Activities Director (AD) also has access to $85 and will issue personal funds to the residents. The AA stated that she works Monday through Friday, from 8:00 AM until 4:30 PM and the AD works on the weekends at times. On 03/02/23 at 10:50 AM, in an interview with the AD, she confirmed that she has $85.00 to issue to residents and that she and the AA are the only staff who have access to the residents' personal fund account. She also confirmed that she works one weekend a month. She explained that the residents know to ask for any money they may need for the weekend by Friday of each week because there is no one at the facility to give the residents money. On 03/02/23 at 11:36 AM, in an interview with the AA, she confirmed that no other staff have access to resident personal funds on weekends and that resident ask for any money they may need for the weekend by Friday. On 03/02/23 at 1:12 PM, in an interview with the Administrator, she stated that residents are supposed to have access to their money on weekends and she was unaware that they did not. She explained that the facility has Management staff at the facility seven (7) days a week. On 03/02/23 at 1:20 PM, in an interview with the Corporate Administrator, she confirmed that weekend management does not have access to see if residents have money available in their personal fund account. Record review of the "Face Sheet" revealed the	F 567	Policy in accordance to with CFR483.10(f)(10)(i)-(ii) "Hold, safeguard, manage, and account for", by the facility Administrator. In addition, on 3/9/2023 & 3/10/2023, in-services were conducted to employees on the facility policy and procedure for Resident Funds by the facility Administrator. A complete review of the facility grievances from 1/1/2022 to current was conducted with no grievances noted regarding lack of access to resident funds through 3/16/2023. Activity Department will maintain a petty cash fund to dispense at resident's request beginning 3/14/2023. The Resident Fund policy and procedure will be discussed during our monthly Resident Council Meetings beginning 3/20/2023. The Activity Director will interview a sample of 5 residents per week regarding resident trust fund grievances beginning on 3/8/2023 for 4 weeks. The Activity Director will bring any adverse findings to the weekly Quality Assurance meeting beginning on 3/28/2023 for a total of 4 weeks, and then to Quality Assurance meeting monthly thereafter 4/27/2023 x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 567	Continued From page 3 facility admitted Resident #68 on 8/03/22 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/22 revealed Resident #68 had Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately Impaired. Record review of the "Trust Fund Trial Balance" report revealed Resident #68 had a personal trust account at the facility. Record review of the "Trust Fund Transaction List" with transaction dates from 2/1/23 through 2/28/23 revealed that no resident trust fund transactions took place on a weekend for February 2023.	F 567		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		4/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 640	Continued From page 4 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to transmit Minimum Data Set (MDS) Assessments by their target date, for 19 of 24 residents reviewed for MDS assessments. Resident #1, #2, #4, #17,	F 640	F640- Encoding/Transmitting Resident Assessments CFR(s) 483.20(f)(1) The Minimum Data Sets (MDS)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 640	Continued From page 5 #25, #32, #36, #37, #62, #65, #69, #72, #74, #78, #79, #83, #86, #93, and #104. Findings include: Review of the Memorial Driftwood Nursing Center MDS Policy with a revision date of 06/30/2019 revealed, "Standard:...IX. Transmission of MDS...All MDS will be transmitted...i. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan completion date...ii. All other MDS assessments must be submitted within 14 days of the MDS completion date..." Record review of MDS Assessments on 2/27/23, revealed the following: 1. The quarterly assessment for Resident #1 with a target date of 1/23/23, and the discharge MDS with a target date of 1/24/23, had not been transmitted. 2. The quarterly assessment for Resident # 2, with a target date of 1/20/23, had not been transmitted. 3. The quarterly assessment for Resident #4, with a target date of 1/2/23, had not been transmitted. 4. The quarterly assessment for Resident #17, with a target date of 1/25/23, had not been transmitted. 5. The yearly assessment for Resident #25, with a target date of 1/20/23, had not been submitted. 6. The quarterly assessment for Resident #32, with a target date of 1/13/23, had not been transmitted. 7. The quarterly assessment for Resident #36, with a target date of 1/18/23, had not been transmitted. 8. The annual assessment for Resident #37, with a target date of 1/16/23, had not been	F 640	Assessments for Residents #1, #2, #4, #17, #25, #32, #36, #37, #62, #65, #69, #72, #74, #78, #79, #83, #86, #93, and #104 were transmitted on 3/2/2023 by the facility MDS Department. All residents with MDS assessments have the potential to be affected by the alleged deficient practice on 3/2/2023. The facility MDS Department Registered Nurse were trained on facility MDS Policy, RAI Manual regarding Encoding data and Transmitting data, and the importance of timely transmission of MDS Assessments on 3/2/2023 by the Corporate Administrator. Weekly MDS transmissions were implemented on 3/2/2023. The MDS RN Coordinator will bring the weekly MDS Submission Reports to the Director of Nursing, Quality Assurance Nurse weekly for review of compliance beginning on 3/8/2023 for a total of 4 weeks. Quality Assurance Nurse will bring the weekly submission report for review and compliance to the weekly Quality Assurance Committee meeting on April 5,2023, and to our monthly Quality Assurance meeting on April 27, 2023, X 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 640	Continued From page 6	F 640		

transmitted.
9. The quarterly assessment for Resident #62, with a target date of 1/10/23, had not been transmitted.
10. The quarterly assessment for Resident #65, with a target date of 1/11/23, had not been transmitted.
11. The quarterly assessment for Resident #69, with a target date of 1/22/23, had not been transmitted.
12. The quarterly assessment for Resident #72, with a target date of 1/10/23, had not been transmitted.
13. The annual assessment for Resident #74, with a target date of 1/12/23, had not been transmitted.
14. The quarterly assessment for Resident #78, with a target date of 1/17/23, had not been transmitted.
15. The quarterly assessment for Resident #79, with a target date of 1/24/23, had not been transmitted.
16. The quarterly assessment for Resident #83, with a target date of 1/13/23, had not been transmitted.
17. The quarterly assessment for Resident #86, with a target date of 1/17/23, had not been transmitted.
18. The Resident quarterly assessment for Resident #93, with a target date of 1/18/23, had not been transmitted.
19. The quarterly assessment for resident #104, with a target date of 1/23/23, had not been transmitted.

An interview on 3/1/23, at 3:30 PM, with the Registered Nurse/MDS Coordinator and RN #1, revealed they are responsible for transmitting MDS assessments. They confirmed that they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 640	Continued From page 7 completed the assessments but had not had enough uninterrupted time in their office to input the assessments and transmit them. The MDS-RN Coordinator revealed that she had notified the Corporate Administrator that they were behind in their MDS responsibilities. In an interview on 3/1/23, at 3:50 PM, with the Corporate Administrator, she confirmed that in January, the MDS-RN Coordinator had made her aware that they were behind in their work. She stated that the MDS nurses admitted that they had many times left their office to assist some of the lesser experienced nurses during the time the facility had been without a Director of Nurses (DON). The Corporate Administrator revealed that she had not put anything in place to ensure the MDS staff were provided the time that they needed to complete their responsibilities. She confirmed that the purpose of the MDS assessments is for case mix and if not done, it could lead to issues related to resident care and proper funding. During an interview on 3/1/23 at 4:12 PM, with the Administrator, she revealed that she knew that the MDS staff had been behind in their work in January, however, she was unaware that they were currently behind. The Administrator admitted that during the time the facility was without a DON, the MDS nurses had assisted as needed, but that the facility had not been short staffed enough to require the MDS nurses to have to do anything that would prevent them from doing their job. The Administrator stated the purpose of the MDS assessments is to determine the care needed for the residents and ensure payment.	F 640		
F 645 SS=D	PASARR Screening for MD & ID	F 645		4/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 645	Continued From page 8 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 645	Continued From page 9 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review and facility policy review the facility failed to complete a Pre-Admission Screening and Resident Review (PASRR) Level II for one (1) of three (3) PASRRs reviewed. Resident #6 Findings include: Record review of the facility policy titled, "(Proper	F 645	F645- PASARR Screening for MD & ID CFR(s) 483.20(k)(1)-(3) Resident number #6, that was identified to be out of compliance regarding a Preadmission Screening and Resident Review (PASRR) Level II, the MS PASRR Level II Change in Status Request Form was completed and faxed on February 28,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 645	Continued From page 10 Name of Facility)-Resident Assessment in Coordination with PASRR Program" with a revision date of 02/01/2019 revealed, " ...Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening ...a. ii. Positive Level I Screen-necessitates a PASRR Level II evaluation prior to admission. b. PASRR Level II-a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD (Mental Disorder) , ID (Intellectual Disorder) or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs ..." An interview on 2/28/23 at 2:30 PM, with Social Services (SS) #1, revealed she could not find the completed PASRR Level II for Resident #6, but she had called the Qualified Independent Contractor (QIC) and spoke with a Representative. She revealed that the QIC Representative implied that the PASRR Level II had been completed and she would fax a copy to the facility. She said that once the facility receives a written notice for a need for a Level II, the QIC will call them to set up the assessment via a telephone call. An interview on 3/1/23 at 9:30 AM, with SS #1, revealed that Resident #6 should have had a PASRR Level II completed in June of 2022. The QIC did call to complete the Level II at some point, but the resident was in the hospital and SS #1 did not follow up once the resident returned to	F 645	2023. Resident #6 was independently evaluated/interviewed by the qualified independent contractor (QIC) on 3/8/2023. Residents identified with mental disorder(s) and/or intellectual disorder(s) have the potential to be affected by the alleged deficient practice on 3/2/2023. All residents admitted, readmitted and those with change in status for mental disorder(s) and/or intellectual disorder(s) as of 1/1/2022 to current were audited and in compliance on 3/6/2023, by Social Services. Social Services will monitor resident admissions, resident readmissions and residents with status changes through the PASRR Level II Tracking Tool on a daily basis as of 3/6/2023. The PASRR Level II Tracking Tool will be presented at the weekly Quality Assurance Meeting beginning 3/6/2023 for a total of 4 weeks. The Quality Assurance Committee will review for compliance and offer recommendations on all tracked information at weekly Quality Assurance meeting beginning 4/5/2023 and to our monthly Quality Assurance meeting on April 27, 2023, X 3 months. monthly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 645	Continued From page 11	F 645		

the facility to ensure the Level II was completed. She confirmed that the resident had a diagnosis of Schizophrenia on admission and the purpose of a PASRR Level II is to get the guidance from the QIC regarding specific care for the resident. She revealed that the resident not having his PASRR Level II completed could have caused the resident's care to be lacking, because the facility would not have known if there were any additional services recommended.

An interview on 3/1/23 at 10:25 AM, with the Director of Nurses (DON), confirmed that Resident #6 had a diagnosis of Paranoid Schizophrenia and Post Traumatic Stress Disorder (PTSD). She confirmed that if the resident needed a PASRR Level II screening, then the resident should have had it done. She confirmed that if the resident had not had the PASRR Level II then a lot of things could have happened, such as behaviors that could have affected the resident or other resident's and the resident would not have received the services that were recommended based on the PASRR Level II assessment.

An interview on 3/1/23 at 2:15 PM, with the Administrator, revealed the purpose of the PASSR is to determine if the residents are appropriate for nursing home placement. She revealed that a PASRR Level II is used to determine any special services that the resident may need based on their diagnosis. She revealed that if the resident had a diagnosis of Paranoid Schizophrenia and PTSD and did not get a PASRR Level II, then the resident might have missed some needed services.

Record review of the "Face Sheet" revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE 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) COMPLETION DATE
F 645	Continued From page 12	F 645		

facility admitted Resident #6 on 3/23/22 and he had medical diagnoses that included Paranoid Schizophrenia, Anxiety Disorder, Unspecified, and Post-Traumatic Stress Disorder, Unspecified.

Record review of the Pre-Admission Screen (PAS) for Resident #6, dated 03/22/22, revealed the PAS was completed by hospital staff prior to admission to the facility and did not indicate the resident had a medical diagnosis of a mental illness.

Record review of the Pre-Admission Screen which was electronically submitted on 05/30/2022 after admission to the facility, revealed Resident #6 had a major mental illness.

Record review of a notice from the QIC revealed, "Notice of Need for Level II PASRR Screen" with a "Review Date" of 6/3/22, which indicated Resident #6 required a Level II evaluation.

Record review of a notice from the QIC revealed, "Notice of Need for Level II PASRR Screen" with a "Review Date" of 2/28/23, which indicated Resident #6 required a Level II evaluation. This document was faxed by the QIC on 2/28/23 after the inquiry by SS #1.