STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Springs Health & Rehabilitation Center	1199 Ocean Springs Road Ocean Springs, MS 39564

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to ensure a resident's right to dignity and respect when staff required her to wear a brief against her preference instead of providing a bedpan or assistance to the bathroom for one (1) of (22) sampled residents, Resident #109.Findings include:On 9/9/25 at 11:05 AM, in an interview, Resident #109 reported that the night shift staff told her she would need to wear a brief rather than being assisted to the bathroom or put on a bedpan, despite her reporting that she does not wear briefs. On 09/10/2025 at 4:15 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that Resident #109 was already admitted to the facility when she came on shift and she recalled that she thought the resident was wearing a pull-up at that time, and she suggested that a brief might be easier than a pull-up since it would not require pulling up and down. LPN #1 confirmed that the evening shift staff, including herself, used a bedpan for the resident, and she personally assisted the resident onto the bedpan, which she tolerated well. She stated she did not know why the night shift staff chose not to use the bedpan and instead placed the resident in a brief. On 09/11/2025 at 11:00 AM, during a follow-up interview with Resident #109 and her daughter, both explained that when the resident was admitted to the facility, she was not wearing a pull-up or a brief. The daughter stated she dressed the resident at the hospital and confirmed she was wearing panties with an incontinence pad for accidents. The resident reported she continues to wear panties and does not want to feel degraded or disrespected by being asked to wear a brief. She emphasized that she never requested either a brief or a pull-up. The resident explained that when staff attempted to place a brief on her, she objected and only stated that if staff insisted, a pull-up would be preferable to a brief. On 09/11/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained that she does not expect any staff to place a brief or pull-up on a resident who is continent, as this is both a resident rights and dignity issue.A record review of the admission Record revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery.A record review of the BIMS (Brief Interview for Mental Status) document, with an Effective Date of 09/10/2025 revealed Resident #109 was cognitively intact.

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor a resident's request for assistance in obtaining personal identification, resulting in a delay of more than one (1) year without follow-up affecting her autonomy and ability to exercise her rights related to personal identification and community access for (1) of (22) sampled residents, Resident #48. Findings include:On [DATE] at 12:31 PM, in an interview, Resident #48 stated she had requested assistance from the facility in completing paperwork and obtaining a state identification (ID) card but that her request had not been fulfilled.On [DATE], at 8:34 AM, during an interview, the Social Services Director stated she had no knowledge of Resident #48's request for assistance with obtaining an ID. She reported the resident frequently brought her insurance mail but had not made the ID request directly to her, acknowledging that the resident may have told the Social Services Assistant instead. On [DATE] at 10:50 AM, during an interview, Social Services Assistant (SSA) #1 recalled Resident #48 previously requested transportation to the Department of Motor Vehicles (DMV) to renew her license and obtain a state ID. SSA #1 stated the resident's out of state driver's license and state ID were expired, and the resident was informed that a birth certificate was required. SSA #1 reported the request had not been resolved due to turnover in the social services department and lack of follow-up from the prior Social Worker. She confirmed the resident had been transported to multiple DMV locations but was unsuccessful each time because she did not have a birth certificate. SSA #1 explained that the resident would need to apply for a birth certificate through another country's embassy before the ID could be obtained.On [DATE] at 4:45 PM, during a follow up interview, the Social Services Director confirmed that the SSA had knowledge of the process to obtain a birth certificate and acknowledged that the matter had not been resolved for Resident #48.On [DATE] at 5:25 PM, during an interview with the Administrator, he revealed his expectations for the Social Services Department are to ensure resident requests are honored.A record review of the admission Record revealed the facility initially admitted Resident #48 on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and resident council interview, the facility failed to provide residents or their resident representatives (RRs) with copies of the Resident [NAME] of Rights and admission documents at the time of admission, with the potential to affect all newly admitted residents by depriving them of required information about their rights and responsibilities upon admission for one (1) of 22 sampled residents (Resident #26).Findings include:A review of the facility's admission Agreement revised 5/25, revealed that Section #20 (items a-o) requires residents or their representatives to sign acknowledging receipt of copies received including the Resident [NAME] of Rights, Resident Handbook, and other admissions documents.On 9/8/202 at 2:00 PM, during a resident council meeting, Resident #26 stated she did not recall receiving admission information during the admission process. She stated she was admitted to the facility on [DATE]. On 9/10/25, at 4:45 PM, an interview with the admissions Coordinator, who has been employed in the position since January 2025, revealed that she has not provided residents or their representatives with a copy of the Resident [NAME] of Rights or the resident handbook during the admission process. She stated that since the facility's recent acquisition, staff have not been able to order resident handbooks and that resident rights documents were not available to distribute. She acknowledged that although residents and representatives signed the admission agreement acknowledging receipt of the items, she had no materials available to provide.On 9/11/25, at 12:23 PM, during a follow up interview, Resident #26 stated she admitted herself and did not recall receiving a folder with signed admission documents unless her daughter may have taken it.On 9/11/25, at 12:46 PM, the Resident #26's emergency contact and relative stated that no admission paperwork was sent home with her following Resident #26's admission.On 9/11/25, at 2:58 PM, the Admissions Director stated she had completed Resident #26's admission paperwork face-to-face on a Saturday. She recalled verbally explaining the documents but admitted she did not provide physical copies to the resident because she did not have access to a copier in the field. She confirmed that Resident #26 did not receive any admission documents during the admission process.Record Review of the admission Record revealed the facility admitted Resident #26 on 8/30/2025 with diagnoses including Surgical Aftercare following Surgery on the Nervous System.Record review of admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/6/2025, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to personal privacy by posting identifying hospice information on a resident's door for one (1) of 22 sampled residents. Resident #85.Findings include: A review of the facility's policy, Resident Rights dated 11/30/2014, revealed . The Facility will not use or disclose the resident's health information without the Resident's authorization.On 9/8/25 at 10:26 AM, during an observation of Resident #85's room, signage was posted on the resident's door sign labeled (Proper Name of Hospice Provider) with the resident's first initial and last name highlighted in yellow stated Call (Proper Name of Hospice Provider) First. Resident #85 was lying in bed and was unable to verbalize awareness of hospice services or knowledge of the signage posted on her door.On 9/8/25 at 12:40 PM, during a phone interview with Resident #85's resident representative (RR), she reported that she had not requested the hospice sign to be placed on her mother's door. She explained that the sign was placed there by the hospice provider.On 09/10/2025 at 1:20 PM, during an interview and observation with the Hospice Coordinator, she confirmed the sign posted on Resident #85's door regarding hospice services and acknowledged she was aware that signage disclosing resident-specific health information should not be posted. She confirmed the sign was clearly visible to anyone passing by the room. She stated she did not authorize the posting of the signage and had not been informed that it had been placed.On 09/10/2025 at 1:50 PM, during an interview with the Director of Nursing, she stated she was not aware that a hospice sign had been posted on Resident #85's door. She explained that staff are trained and aware that resident privacy must be protected and that personal health information should not be displayed. She was unsure whether hospice staff or another individual placed the sign. She stated it is her expectation that staff would notify her immediately if any signage containing resident-specific health information is posted, and that such signage be removed right away. On 09/11/2025 at 02:40 PM, during an interview with the Administrator, he confirmed he had been informed that Hospice had placed a sign on a resident's door. He explained there should never be any posting of signage containing resident-specific health information, as this violates a resident's right to privacy and dignity.A record review of the admission Record revealed the facility admitted Resident #85 on 10/16/24 with current diagnoses including Dementia. A record review of Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/25 revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident's cognition was severely impaired. A review of Section O revealed she was receiving hospice care.A record review of the Order Summary Report revealed Resident #85 had a Physician's Order, dated 1/30/25, to admit the resident to hospice services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, record review, facility investigation and facility policy review, the facility failed to implement its abuse prevention policy by not reporting and investigating an allegation of misappropriation of resident property in a timely manner for one (1) of 22 sampled residents, Resident #106.Findings Include:A review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation, revised 11/16/2022, revealed, .7. Reporting/Response: Any employee or contracted service provider who.has knowledge of.an allegation of.misappropriation of resident property.is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations . Review of report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State Law, including to the State Agency, within 5 working days of the incident .A record review of the facility's investigation emailed to the SA on 7/3/25, revealed, .Please accept this email as formal, initial notification of misappropriation of funds that occurred on June 27, 2025 . The investigation detailed that on 6/27/25, Resident #106 reported Certified Nursing Assistant (CNA) #1 was seen handling her change purse and that coins were missing. The record further showed the incident was not reported timely to the State Agency (SA) as required by facility policy. On 9/10/25 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #2, she explained that on 6/27/25, while providing wound care to Resident #106, she turned the resident and noticed quarters stuck to her back and a small red change purse tucked inside her gown. LPN #2 stated the resident typically kept the change purse on her overbed table. When she asked the resident about it, the resident reported she had been napping earlier that morning, awoke to a noise, and observed Certified Nursing Assistant (CNA) #1 at her bedside with her change purse open and removing quarters. The resident told LPN #2 she believed money was missing. LPN #2 stated she immediately reported the allegation to the charge nurse on duty, who then reported it to the Director of Nursing (DON). On 9/11/25 at 10:50 AM, during an interview with the DON, she explained that the incident was not reported within required timeframes because leadership initially debated the credibility of the allegation. She confirmed that the allegation should have been reported immediately, in accordance with facility policy, and acknowledged that the delay was a violation of the policy. On 9/11/25 at 11:25 AM, during an interview with the Administrator, he confirmed he did not initially report the allegation because the resident stated she did not want to make a big deal about it. He acknowledged awareness of the facility's policy requiring all allegations of abuse or misappropriation to be reported immediately.A record review of the admission Record revealed the facility admitted Resident #106 to the facility on 7/16/2023 with current diagnoses including Type 2 Diabetes Mellitus.A record review of the Quarterly Minimum Data Set (MDS) with an ARD of 07/08/2025 revealed Resident #106 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated she was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for residents who are dependent upon staff, related to incontinence care (Resident #109) and shaving (Resident #91) for two (2) of 22 sampled residents.Findings include:A review of the facility's policy, Activities of Daily Living (ADLS) dated 02/01/2022, revealed . To encourage resident choice and participation in activities of daily living (ADL) and provide.assistance as necessary . ADLs includes bathing, dressing, grooming, hygiene, toileting . Procedure.2. CNA (Certified Nurse Aide) will provide needed . assistance to resident.Resident #109On 9/9/25 at 11:05 AM, during an interview, Resident #109 reported she had been left in a soiled brief since 6:00 AM. She stated she pushed the call light several times, but staff turned the light off without returning to provide care. The resident's daughter, present at the time, confirmed she arrived at 9:00 AM, remained until 10:10 AM, returned at 10:30 AM, and no staff had checked on or changed the resident during that time.On 9/9/25 at 11:30 AM, during an interview, Certified Nursing Assistant (CNA) #1 reported she had not checked on or changed Resident #109 during her shift and stated she had been told in report that the resident went to the bathroom independently. She acknowledged she was not familiar with the resident.On 9/9/25 at 11:45 AM, during an observation, CNA #1 checked Resident #109 and confirmed her brief was saturated, and the bed was soiled, requiring a complete bed change.On 9/9/25 at 11:50 AM, during an interview, the facility Ombudsman stated the facility had received numerous complaints from residents being left in soiled briefs for long periods of time.On 09/11/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained all staff are to be aware of residents' needs to provide the appropriate quality of care for each resident and that a resident left in a soiled brief for hours is not acceptable. A record review of the admission Record revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery. Resident #91On 9/8/25 at 11:11 AM, during an observation, Resident #91 was lying in bed watching television. Thick facial hair was noted on the resident's chin and neck. The resident stated she liked to have her facial hair shaved but staff often forgot to do so.On 9/9/25 at 4:15 PM, during an observation, Resident #91 remained with long facial hair. She stated she disliked having facial hair, but that staff forgot to shave her. On 9/9/25 at 4:30 PM, during an interview, CNA #2 explained Resident #91 was a day-shift shower/bath resident and female residents were supposed to be shaved on shower days. She stated whether Resident #91 was shaved was dependent upon the CNA assigned and acknowledged the resident currently had long facial hair. CNA #2 stated Resident #91 was always cooperative and did not refuse care.On 9/10/25 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #2 stated she noticed Resident #91 with long facial hair both the previous day and that morning. She explained that CNAs were instructed and in-serviced to provide shaving during bathing or shower care. She confirmed Resident #91 did not refuse care and was cooperative.On 9/10/25 at 2:10 PM, during an interview, the DON stated residents were to be shaved during ADL care, including women. She stated a female resident with long facial hair on her chin was not acceptable and staff were expected to provide the needed care.On 09/11/2025 at 2:30 PM, during an interview with the Administrator, he confirmed that residents left sitting in urine or not receiving timely care was unacceptable and not consistent with facility practices. He stated he expects all residents who are dependent on staff for ADLs to be treated in a dignified manner. He further explained that if staff observe long facial hair, especially on a female resident, it is their responsibility to provide shaving unless the resident refuses, in which case the refusal must be documented in the record. A record review of the admission Record revealed the facility admitted Resident #91 on 11/16/22 with diagnoses including Paraplegia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #91 was dependent on staff for personal hygiene, toileting, and bathing.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview, the facility failed to post daily nurse staffing information in a prominent place readily accessible to residents, staff, and visitors for four (4) of (4) days of survey, which had the potential to affect all 108 residents residing in the facility.Findings include:On 9/8/25 at 10:00 AM, during an initial tour of the facility, there was no daily staffing information posted throughout the building. There was a stop sign on the entranceway door asking staff and family not to allow residents beyond the double doors into the entrance hall.On 9/9/25 at 8:00 AM, during a walkthrough of the facility, the State Agency (SA) did not observe the required daily posting of staffing information.On 9/10/25 at 9:00 AM, during a walkthrough of the facility, the SA did not observe the required daily posting of staffing information.On 9/11/25 at 11:55 AM, during an interview, Licensed Practical Nurse (LPN) #4 stated that the staffing was usually taped on the table in the entrance hallway next to the visitor sign-in book. LPN #4 confirmed she failed to tape the staffing information on the table on 9/8/25, but she did on 9/9/25 through 9/11/25. LPN #4 confirmed residents do not frequent the entrance hallway and acknowledged the sign on the door indicating, Do not allow residents to go beyond this door. LPN #4 stated she had not been posting the daily staffing in a place where all visitors, staff, and residents could see it. She stated she had been told to tape the daily staffing information on the table in the entrance hall daily but was not aware of the regulation requiring staffing to be posted in a prominent area where residents, family, and visitors could see it.On 9/11/25 at 3:30 PM, during an interview, the Administrator and the Director of Nursing (DON) both confirmed the daily staffing postings did not meet the regulatory requirements of being in an area accessible to residents. They confirmed there was a sign asking staff and visitors not to allow residents beyond the double doors into the entrance hall, which prevented residents from seeing the daily posted staffing information. The DON stated the Staff Development Nurse was responsible for posting the daily staffing, including all required information, and ensuring it was posted where everyone could see it. The Administrator and the DON confirmed residents did not frequent the entrance hall and stated they would place the staffing information in a glass case where it would be visible to everyone going forward.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to maintain food quality and hygienic practices in accordance with professional standards for food safety related to overly ripened produce, improperly stored food, exposed food, expired food, and unsanitary handling of ready-to-eat food for two (2) of (2) kitchen observations.Findings include:A review of the facility's policy, Sanitation Inspections, Nutrition, and Food Service, with an effective date of 11/30/2014, revealed, .Each item is labeled and dated before refrigeration. Avoid indiscriminate handling of foods with fingers. The proper use of hands, gloves and serving utensils shall be taught to all food handlers .On 09/08/2025 at 10:15 AM, during an observation and interview of the kitchen with the Dietary Manager (DM), Refrigerator #1 was observed to contain two (2) small plates with individual portions of lettuce, tomato, and onions that were not dated, and one (1) cut piece of overly ripe cucumber with dark spots. Refrigerator #2 was observed to contain four (4) bunches of overly ripe celery with withered leaves that were soft and flexible, one (1) opened bag of salad mix with a manufacturer's Best if Used By date of 9/4/25, and five (5) heads of iceberg lettuce with slimy dark leaves and visible white biological growth. The pantry was observed to have a flour bin with the lid left open, exposing the flour, and opened gallon-sized bottles of teriyaki sauce and soy sauce with manufacturer instructions to refrigerate after opening. The DM acknowledged the overly ripe produce, exposed and expired food, and improper storage. He stated he and the cook were responsible for maintaining food quality and that staff were in-serviced monthly on food safety.On 09/09/2025 at 11:19 AM, during a follow-up observation of the kitchen service line and staff interviews with the Baker, she was observed preparing resident trays while picking up bread rolls and pieces of fried fish with her gloved hands, arranging chicken and potatoes on plates with her gloved hands. The [NAME] confirmed she was handling food with her gloved hands and acknowledged the importance of using sanitary practices to prevent cross-contamination. She stated staff received food safety in-services every two (2) weeks. During the same observation, a Dietary Aide (DA) was observed removing a serving spoon from a pan of potatoes, using it to push chicken from one plate to another, then using the same spoon to serve carrots. The DA was further observed placing bread rolls and pieces of fried fish on plates with her gloved hands. In an interview at this time, the DA acknowledged she had handled food with her gloved hands and confirmed she knew food should be handled with proper utensils. She stated staff received in-services on food safety every (2) months. The DM acknowledged the unsanitary handling of food observed during tray service. He stated his expectation was for staff to use utensils for ready-to-eat foods to prevent contamination and foodborne illness. He reported he would conduct additional staff training.On 09/11/2025 at 11:37 AM, during an interview, the Administrator acknowledged he was made aware of the observations of overly ripe produce, exposed food, expired food, and unsanitary food handling practices. He confirmed that it was the responsibility of the DM and [NAME] to maintain food safety standards and stated he would implement daily monitoring to ensure compliance.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to accurately report staffing data to the Centers for Medicare and Medicaid Services (CMS) using payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, FY (Fiscal Year) Quarter 3 2025 (April 1-June 20) resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN) hours, and no licensed nursing coverage 24 hours/day.Findings include:A record review of the Payroll Based Journal (PBJ) Staffing Data Report for the third (3rd) quarter (4/1/25 through 6/30/25) revealed the facility triggered for Excessively Low Weekend Staffing, No RN Hours, and Failed to Have Licensed Nursing Coverage 24 Hours/Day. Further review revealed the Infraction Dates for No RN Hours and Failure to Have Licensed Nursing Coverage 24 Hours/Day were 4/1/25 through 4/30/25 and 5/1/25 through 5/31/25.A record review of the Staffing Grid, completed by Human Resources staff member Licensed Practical Nurse (LPN) #4, revealed the facility had RN and nursing coverage on all days in April and May 2025.A record review of the facility's time sheets revealed the facility was not excessively low on staff on the weekends, had licensed nursing coverage 24 hours per day, and had eight (8) hours of Registered Nurse (RN) coverage daily.On 9/11/25 at 1:00 PM, during an interview, LPN #4 stated she was unaware the facility failed to electronically submit PBJ staffing data to CMS accurately for the third quarter of 2025. She confirmed she was responsible for creating the staffing schedule and stated that during April, May, and June 2025, salaried staff helped cover the schedule as needed.On 9/11/25 at 2:00 PM, during an interview, the Human Resources Coordinator stated the corporate office was responsible for submitting the PBJ staffing data for all the corporation's facilities. She stated she was unaware the PBJ staffing information submitted for this facility was inaccurate until she was notified by the State Agency.On 9/11/25 at 3:30 PM, during an interview, the Administrator stated he was not aware the facility failed to electronically submit PBJ staffing data accurately during the third quarter of 2025. He stated the corporate office had been responsible for submitting PBJ staffing data for all the corporation's facilities. The Administrator stated he understood the importance of accurately reporting PBJ information to CMS and acknowledged it was ultimately the facility's responsibility to ensure accuracy. He stated the facility changed ownership to a new company on 6/1/25, and the PBJ data errors occurred under the prior corporate ownership. The Administrator stated he believed a glitch in the prior corporation's system caused the PBJ data inaccuracies and confirmed the infractions occurred only in April and May 2025. He stated no PBJ infractions occurred after the new ownership assumed operations on 6/1/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Springs Health & Rehabilitation Center	1199 Ocean Springs Road Ocean Springs, MS 39564

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent the recurrence of previously cited deficiencies, specifically, the facility was cited for failing to accurately submit direct care staffing information and failed to ensure the QAPI program was sustained during transitions in leadership to maintain implemented procedures during an annual recertification survey on 4/18/24 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for two (2) of (11) deficiencies cited. F851 and F865/867. Findings Include: Review of the facility's policy, Performance Improvement (QAPI), dated 6/1/25, revealed, . The Center and organization have an ongoing Performance Improvement Program with a design and scope that is ongoing and comprehensive.The design and scope of the program is to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement.Procedure: The Center Executive Director is accountable for the overall implementation.The Center identifies areas for continuous quality monitoring and the monitoring tools to be used.The Performance Improvement (QAPI) Committee reviews and coordinates the proposed activities and identifies the priorities for the coming year.Criteria for selecting aspects of care for improvement are based but not limited to.Regulatory - previous or current regulatory items or identified concerns. Record review of the Provider History Profile revealed the facility received a citation for F851 - Payroll Based Journal and F865-QAPI Program/Plan. Record review of the Centers for Medicare and Medicaid Services (CMS)- 2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 4/18/24, revealed the facility received a citation for F851, .Based on staff interview, record review, and facility policy review, the facility failed to accurately submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for Quarter 1 of Fiscal Year (FY) 2023 (October - December 2023) for one(1) of five (5) quarters reviewed and for F865, .Based on staff interview, record review, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAI) Committee failed to ensure the program was sustained during transitions in leadership and failed to maintain implemented procedures and monitor the interventions the committee put into place in April 2022. This was for two (2) recited deficiencies originally cited in April 2022 on an annual recertification survey. The deficiencies were in the area of residents' rights and wounds. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of eight (8) deficient practice citations. During the current recertification survey, the facility failed to accurately report staffing data to CMS using payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN) hours, and no licensed nursing coverage 24 hours/day and failed to sustain corrective actions to prevent recurrence of previously cited deficiencies.On 9/11/25 at 5:15 PM, during an interview with the Administrator, he explained that QAPI meetings are conducted quarterly, as well as on an as-needed basis when issues arise. He stated that staff report concerns to him or the Director of Nursing (DON), and he compiles the information for review during the QAPI meetings. He acknowledged that the repeat deficient practice related to Payroll-Based Journal (PBJ) reporting has continued. In his view, the issue is due to a processing glitch, explaining that when information is transmitted to CMS, he believes there may be an error within the Information Technology (IT) department that results in the discrepancies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Springs Health & Rehabilitation Center	1199 Ocean Springs Road Ocean Springs, MS 39564

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	255142	A. Building B. Wing	09/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to prevent the possible spread of infection by not implementing contact isolation precautions timely for (Resident #47) and enhanced barrier precautions (EBP) when providing care for (Resident #4) for two (2) of 22 sampled residents.Findings include:A review of the facility's Policies and Practices - Infection Control, revised October 2018, revealed, This facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. Policy Interpretation and Implementation.2. The objectives of the infection control policies and procedures are to: a. Prevent, detect, investigate, and control infections in the facility b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions.A review of the facility's policy, Enhanced Barrier Precautions, dated August 2022, revealed, . Enhanced barrier precautions (EBPs) are used to prevent the spread of multidrug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. A. Gloves and gowns are applied prior to performing high-contact resident care activity.Resident #47On 9/8/25 at 10:00 AM, during an observation, there was no signage on doors on the 500 Hall indicating residents were on contact isolation precautions. Resident #47, who resides on the 500 Hall, was in her room, lying in bed with his eyes closed. There was no signage on the door indicating contact isolation precautions. On 9/9/25 at 9:08 AM, during an observation, there was signage on Resident #47's door as well as personal protective equipment (PPE) indicating the resident was on contact isolation. Red barrels with biohazard bags were also placed inside the resident's room.On 9/9/25 at 10:15 AM, during an interview, Registered Nurse (RN) #2 stated Resident #47 had tested positive in the hospital for COVID-19 and was admitted to the facility on [DATE]. RN #2 stated she was not working on 9/5/25 and confirmed the facility failed to follow infection control protocol at the time of admission by not placing the resident on isolation precautions. RN #2 stated she normally ensured the contact isolation signage, PPE, and biohazard barrels were placed in the resident's room, and going forward, the admission nurse would assist in ensuring infection control protocols were followed when she was not working. RN #2 confirmed that failing to follow infection control protocol could cause the spread of infection to other residents and staff.A record review of the admission Record revealed the facility admitted Resident #47 on 9/5/25 with diagnoses including COVID-19.A record review of the resident's Entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/25 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she had moderate cognitive impairment.A record review of the Order Summary Report revealed Resident #47 had a Physician's Order, dated 9/8/25, which was three (3) days after admission, for isolation related to a positive Covid-19 test. Resident #4On 9/10/25 at 10:51 AM, during an observation of wound care provided by the Nurse Practitioner (NP), Licensed Practical Nurse (LPN) #2, and Certified Nursing Assistant (CNA) #4, the staff washed their hands and wore gloves, but failed to wear gowns. LPN #2 removed the old bandage on the resident's left hip, and the NP removed staples from the incision. There was no enhanced barrier precautions signage on Resident #4's door.On 9/10/25 at 10:59 AM, during an interview, LPN #2 and CNA #4 confirmed they failed to wear gowns while providing wound care. They stated they typically wore gowns when providing wound care and normally looked for signs on the door stating EBP. They confirmed there was not a sign on the door, and they did not think about wearing a gown at that time.A record review of the admission Record revealed the facility admitted Resident #4 on 8/20/25 with diagnoses including Left Femur Fracture. A record review of the admission MDS, with an ARD of 8/27/25, revealed Resident #4 had a BIMS score of 13, which indicated he was cognitively intact.A record review of the Order Summary Report revealed Resident #4 had a Physician's order, dated 8/21/25 for Enhanced Barrier Precautions related to wounds. On 9/10/25 at 11:17 AM, during an interview, the Director of Nursing (DON) stated staff should wear gowns and gloves when removing staples from an incision or providing wound care. The DON stated EBP required the use of gowns and gloves during wound care, and an EBP sign should have been placed on Resident #4's door. The DON also stated a contact isolation sign and PPE should have been placed on Resident #47's door.On 9/11/25 at