STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	**1199 OCEAN SPRINGS ROAD , OCEAN SPRINGS, Mississippi, 39564**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #3041006), at the facility on 6/22/26. CI MS #3041006 was investigated regarding nursing services, physician services, quality of care, and neglect. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F657 and F684. The facility held a license for 115 beds, with a census of 107.	F0000		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657		

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 reverse for further 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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F0657 SS = D	Continued from page 1 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to revise Resident #1's comprehensive, person-centered care plan to include individualized interventions for physician-ordered wound care for one (1) of three (3) residents reviewed for care planning, Resident #1. Findings include: A review of the facility's policy "Care Plan Revisions Upon Status Change, revised 11/14/2025, revealed, "Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change…Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 5/20/26 with diagnoses including Amputation. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating his cognition was intact. A record review of the "Discharge Instructions" revealed, Resident #1 was discharged from a local hospital on 5/20/26 with "Orders" to "…Change dressing daily and as needed with dry gauze and replace ace wrap…". A record review of the "Order Summary Report" for "Active, Completed, and Discontinued" orders revealed Resident #1 had a Physician's Order, dated 5/29/26, for "Wound…RBKA (right below knee amputation) Clean with wound cleanser, apply Xeroform, cover with ABD, wrap with Kerlix every day shift every Mon (Monday), Thu (Thursday)…" A record review of the "Care Plan Report" revealed Resident #1 had a focus of "I have a surgical wound to the right lower extremity," with a date initiated of 5/29/26. The care plan included interventions to monitor nutritional status, monitor and report changes in skin status, obtain laboratory and diagnostic work as ordered, and complete weekly	F0657		

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F0657 SS = D	Continued from page 2 wound measurements. Resident #1 also had a focus of “I have an amputation of the bilateral lower extremities r/t (related to) Diabetes, infection,” with a date initiated of 5/29/26. The care plan included interventions related to rehabilitation, pain management, monitoring for bleeding and drainage, monitoring nutritional status to promote wound healing, and monitoring the resident's psychosocial adjustment following the amputation. There were no individualized interventions reflecting the physician-ordered wound treatment initiated on 5/29/26, including cleansing the wound with wound cleanser, applying Xeroform, covering the wound with an ABD, wrapping the wound with Kerlix, or performing dressing changes in accordance with the physician's orders. During an interview with Licensed Practical Nurse (LPN)/MDS #2 on 6/22/26 at 1:14 PM, she revealed there were no care plan interventions or approaches addressing Resident #1's wound care needs. She stated the facility develops an individualized, person-centered care plan for each resident based on the resident's assessed needs and physician orders. LPN #2 confirmed Resident #1's wound care should have been incorporated into the comprehensive care plan and acknowledged this was not completed. During an interview with the Director of Nursing (DON) on 6/22/26 at 3:00 PM, she confirmed Resident #1 was admitted to the facility on 5/20/26 with physician-ordered wound care following a right below-the-knee amputation. The DON stated the facility's interdisciplinary team is responsible for developing and updating each resident's comprehensive, person-centered care plan to reflect the resident's current conditions, physician orders, and treatment needs. She acknowledged Resident #1's wound care interventions were not incorporated into the comprehensive care plan after the wound care orders were written on 5/29/26. The DON confirmed the residents' wound care needs should have been included in the care plan to provide staff with individualized guidance for monitoring and managing the resident's wound in accordance with facility policy and professional standards of practice.	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility	F0684		

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F0684 SS = D	Continued from page 3 residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide treatment and services in accordance with professional standards of practice by failing to timely transcribe physician-ordered wound care into the resident's medical record and failing to document physician-ordered wound treatments in the clinical record for one (1) of three (3) residents reviewed for wound care (Resident #1). Findings include: A review of the facility's policy "Documentation of Wound Treatments" revised 11/7/2025 revealed, "Policy: The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment…Policy Explanation and Compliance Guidelines…3. Wound treatments are documented at the time of each treatment…" A review of the facility's policy "Provision of Quality of Care," undated, revealed "Policy: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices…Policy Explanation and Compliance Guidelines…6. Policies and procedures will reflect current professional standards of practice. A. All employees are responsible for following established policies and procedures…" A record review of the "Discharge Instructions" revealed, Resident #1 was discharged from a local hospital on 5/20/26 with "Orders" to "…Change dressing daily and as needed with dry gauze and replace ace wrap…". A record review of the "Order Summary Report" for "Active, Completed, and Discontinued" orders revealed Resident #1 had a Physician's Order, dated 5/29/26, for "Wound…RBKA (right below knee amputation) Clean with wound cleanser, apply Xeroform, cover with ABD, wrap with Kerlix every	F0684		

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F0684 SS = D	Continued from page 4 day shift every Mon (Monday), Thu (Thursday)…" This was the first order on the medical record, which was nine (9) days after the facility admitted him. A record review of Resident #1's clinical record, including the Treatment Administration Record (TAR), revealed no documentation that physician-ordered wound treatments were performed from the resident's admission on 5/20/26 through 5/31/26. On 6/22/26 at 11:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she revealed Resident #1 was admitted to the facility on 5/20/26 with physician-ordered wound care. LPN #1 acknowledged she provided daily wound care but did not transcribe the physician's wound care orders until 5/29/26, nor did she document the wound care on the TAR or clinical record. She stated physician orders should be transcribed promptly, and wound care should be documented at the time the treatment is provided to ensure continuity of care and an accurate medical record. She acknowledged she did not follow facility policy regarding documentation of wound treatment and dressing changes. On 6/22/26 at 3:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident #1's physician-ordered incision/wound care orders were received from the hospital upon the resident's admission on 5/20/26. The DON explained the facility's admission process requires the Admission Nurse to enter all physician orders, including wound care orders, into the facility's computerized medical record upon admission. The DON acknowledged that, in this instance, the Admission Nurse did not enter the hospital's wound care orders into the electronic medical record. Instead, the Admission Nurse provided the paper copy of the hospital wound care orders to a newly hired Registered Nurse (RN), believing the RN would enter the orders into the computerized charting. The DON stated the newly hired RN was unfamiliar with the facility's admission process and did not know she was responsible for entering the physician's orders into the electronic medical record. The DON further stated the facility's wound nurse (LPN #1) was away from the facility for several days following the resident's admission. Upon her return, she received a verbal report regarding Resident #1's wound care and believed the physician's wound care orders had already been entered into the electronic medical record. Approximately nine days after the resident's admission, the wound nurse discovered the wound care orders had not been transcribed into the	F0684		

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F0684 SS = D	Continued from page 5 computerized chart and immediately entered the physician-ordered wound care into the electronic medical record on 5/29/26. The DON confirmed this was a breakdown in the facility's admission process and acknowledged the physician's wound care orders were not transcribed in accordance with facility policy. The DON stated facility staff performed Resident #1's wound care in accordance with the hospital discharge instructions despite the delay in entering the physician's orders into the electronic medical record. The DON acknowledged the wound treatments were not documented on the TAR or in the clinical record until 6/1/26, which was not consistent with facility policy. A record review of the “Admission Record” revealed the facility admitted Resident #1 on 5/20/26 with diagnoses including Amputation. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating his cognition was intact.	F0684		