STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255112	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hills Com LIV Center	1600 Raymond Rd Jackson, MS 39204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42807 Based on facility policy review, record review and interviews the facility failed to ensure that residents were treated and spoken to in a dignified and respectful manner for two (2) of four (4) sampled residents. Resident #1 and Resident #2. Findings include: Review of facility policy titled, Behavior of Employees, revised 12/13/17, revealed, Policy It is the policy of the Company that certain rules and regulations regarding employee behavior are necessary . Appropriate employee conduct includes: a. Treating all residents, visitors, and coworkers in a courteous manner; b. Refraining from behavior or conduct that is offensive . Record review of facility document titled, Resident Rights, revised and implemented on 11/28/16, revealed, (a) Residents Rights. The resident has a right to a dignified existence . (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life . On 4/04/24 at 9:03 AM, during a telephone interview with the facility Ombudsman, she confirmed that she visited the facility at least monthly and visited with residents. The Ombudsman revealed that she had received complaints from residents related to the way Licensed Practical Nurse (LPN) #1 had treated at spoken to them. The Ombudsman stated that residents had reported to her that LPN #1 routinely spoke to them in a loud, rude, and aggressive manner. On 4/04/24 at 11:00 AM, an interview with a Resident, who requested to remain anonymous, revealed LPN #1 was rude and had spoken to her disrespectfully. The resident stated that she had also witnessed LPN #1 speak disrespectfully to other residents. The resident explained that she had witnessed LPN #1 yell at residents to go to bed, go back to your room. The resident stated LPN #1 told the residents what she was going to do and not going to do. She said that she had also witnessed LPN #1 fuss at residents and tell them that she was not going to come back to answer their call light again, so they better tell her everything they wanted or leave the call light alone. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/04/24 at 11:55 AM, during an interview Resident #2 reported that LPN #1, that was rude and disrespectful to her and that she had witnessed LPN #1 being disrespectful to other residents. Resident #2 stated, LPN #1 is always hollering at residents. Resident #2 reported that she had witnessed LPN #1 yelling at residents to go to bed. She stated LPN #1 would tell residents to Get in your room. Go to sleep. The resident described LPN #1 as loud and aggressive. On 4/04/24 at 12:10 AM, an interview with a family member of Resident #2, she reported that she visited the facility frequently during different shifts and had witnessed LPN #1 yelling at residents. The family member stated that she felt it was more than speaking loudly to be heard because LPN #1 was yelling orders at the residents. She provided examples of things she had heard LPN #1 yelling at residents, like telling them to get in their rooms and go to bed. she added, some of these residents didn't even seem to be able to understand. On 4/04/24 at 1:50 PM, in an interview with Resident # 1, the previous Resident Council President, she revealed that the behavior of LPN #1 had been discussed in the Resident Council meetings. The resident stated the Activity Director had taken notes for the meetings, but she was not sure if concerns related to LPN #1 were recorded or not. The resident complained that LPN #1 was rude and disrespectful to residents, especially if she was assigned to their care and they requested anything. Resident #1 commented that it was reported that during a recent incident, when a resident requested something for their cold/allergy symptoms, LPN #1 told the resident No, you can't have that and walked out. On 4/04/24 at 5:00 PM, an interview with the Social Services Director (SSD) revealed that any staff member could document a grievance and that the grievances were turned in to her, and she directed them to the appropriate department head to be addressed. The SSD confirmed that she had received a grievance today from the Staffing Coordinator about a report she had received regarding the loud, rude, and aggressive behavior of LPN #1. On 4/05/24 at 1:58 PM, during an interview with the Staffing Coordinator, she confirmed Certified Nursing Assistant (CNA) #1 reported to her that LPN #1 needed to learn how to talk to people. CNA #1 had stated that LPN #1 was loud and that there had been complaints from residents that they did not like LPN #1's tone or volume and felt she was not speaking to them in a respectful manner. On 4/05/24 at 2:10 PM, an interview with the Assistant Director of Nurse (ADON), revealed the facility provided routine in-service training related to Resident Rights and treating residents with respect. She stated that the facility also provided routine in-service training related to Resident Abuse and Neglect Prevention and Reporting. The ADON commented that she had not witnessed or heard any allegations involving LPN #1 which rose to the level of verbal abuse, but had received a report of an allegation that LPN #1 had spoken to a resident in a rude, disrespectful manner and the allegation was currently being investigated and could result in the termination of the employment of LPN #1 from the facility because LPN #1 had already received multiple coaching and verbal warnings regarding therapeutic communication. Record review of the Record of Corrective Coaching and Witness Statement dated 3/13/24 and signed by the Director of Nurses (DON) revealed that on 3/13/24, LPN #1 received a verbal warning regarding behaviors and attitude and received an additional in-service on conduct of behavior for employee and therapeutic communication. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 9/10/13, with diagnoses that included End stage renal disease and Type 2 diabetes. Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/12/24, for Resident #1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 8/16/22, with diagnoses that included Chronic respiratory failure and Neuralgia. Record review of the 5-Day MDS, with ARD 3/08/24, for Resident #2, revealed the resident had a BIMS score of 12, which indicated no cognitive impairment.