

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER Pleasant Hills Com LIV Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, interview, record review and facility policy review, the facility failed to ensure the resident's right to respectful, dignified care when they failed to apply the indwelling urine catheter collection bag cover, leaving the bag and its contents visible from the hallway for one (1) of three (3) residents with indwelling catheters (Resident #3).</p> <p>Findings include:</p> <p>A record review of the facility's policy titled, Urinary Catheter Care, dated March 14, 2008, revealed, .A privacy bag should be placed over the drainage bag when the resident is to be out in public. This preserves the resident ' s dignity .</p> <p>A record review of the admission Record for Resident #3 revealed the facility admitted the resident on 12/28/2023 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction and Neuromuscular Dysfunction of Bladder.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 5/20/2025 for Resident #3 revealed the resident had no Brief Interview for Mental Status (BIMS) score due to her inability to participate. The MDS documented memory problems and severe cognitive impairment in daily decision-making.</p> <p>On 6/23/2025 at 1:30 PM, during an observation in Resident #3's room, she was seen resting in bed with a catheter urine collection bag (catheter bag) attached to the bed frame. The bag was visible from the open door, displaying approximately three hundred milliliters (300 ml) of clear, yellow liquid. A blue snap-on catheter bag cover was observed hanging unsnapped, failing to conceal the bag or its contents.</p> <p>On 6/23/2025 at 4:30 PM, during an observation and interview with the Director of Nursing (DON) in Resident #3's room, the DON confirmed the catheter cover had not been applied properly and acknowledged that it did not cover the bag or its contents. The DON left the room to locate a catheter bag cover that would provide adequate privacy to uphold Resident #3's dignity.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 255112	If continuation sheet Page 1 of 23

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to provide reasonable accommodation of resident needs and preferences by discontinuing the use of disposable premoistened cleansing cloths for four (4) of thirty (30) sampled residents. (Residents #8, # 9, #14, and #20). Residents and staff were informed that the premoistened disposable cloths could be provided for incontinent residents with wounds, due to their softer texture being less irritating to fragile, damaged, or healing skin. However, the facility failed to make the premoistened disposable cloths available.</p> <p>Findings included:</p> <p>Record review of the facility policy Resident Rights revised and implemented on Nov. 28, 2016 revealed .The resident has a right to be treated with respect and dignity, including .(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents</p> <p>On 6/17/25 at 12:20 PM, during an interview and observation of the facility supply room revealed Registered Nurse (RN) #1 stated We don't use wet wipes (disposable premoistened cleansing wipes). Observation revealed there were no disposable premoistened cleansing wipes in the supply room.</p> <p>On 6/18/25 at 2:10 PM, during an observation and an interview Resident #8 revealed her family purchased disposable premoistened cleansing cloths for her care. She confirmed that she had a wound on her leg for which she was receiving treatment. Regarding the dry disposable cloths, Resident #8 stated those little towels don't work.</p> <p>On 6/18/25 at 4:30 PM, during an interview Resident #14 stated she did not like it that the facility had stopped providing disposable premoistened cleansing wipes. She stated that the facility had replaced the disposable premoistened cleansing wipes with disposable dry wipes which were not soft, were not durable and left lint on her. Resident #14 described the dry disposable cleansing cloths as useless. Resident #14 stated I use those clothes at dialysis to wipe my nose. They are like Kleenex, thin and tear apart too easy. She confirmed she was the Resident Council President and said discontinuation of disposable premoistened cleansing cloths had been discussed at the 6/10/25 meet and greet for the new Director of Nursing (DON). She stated that she had a wound and fragile skin and preferred the disposable premoistened cleansing cloths because their texture was softer than the washable cloths. She stated that the facility had not had an adequate supply of linens since discontinuation of the disposable premoistened cleansing cloths which she said resulted in postponement and interruption of resident care.</p> <p>On 6/20/25 at 12:00 PM, during an interview with the facility Ombudsman on North Unit revealed he stated that he had received complaints from multiple residents regarding lack of clean linen and lack of staff resulting in postponement of resident care. He said he had also had multiple complaints regarding the discontinued provision of disposable premoistened cleansing cloths.</p> <p>On 6/23/25 at 12:53 PM, during an interview with the family of Resident #20 revealed she visited weekly, and family provided needed supplies for the resident's care, including disposable premoistened cleansing cloths since the facility no longer supplied them. She confirmed that Resident #20 had a wound on his right leg.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/23/25 at 2:00 PM, during an interview Resident #9 revealed that he was aware that the facility was not required to supply disposable cleansing cloths but was told that if residents with wounds requested them, they would be provided. He said he had told multiple staff that he preferred the disposable wipes for incontinence care due to the rough texture of the washable washcloths and the fragility of his skin, but none had been provided for him. He said he had never seen any Certified Nursing Assistant (CNA) flush premoistened disposable cleansing cloths. He stated that they always threw them in a trash bag.</p> <p>On 6/23/25 at 4:15 PM, during an interview the DON stated she was aware that the residents had concerns regarding the facilities discontinuation of disposable premoistened cleansing cloths for resident care. She confirmed the disposable cloths' texture was less rough, therefore less irritating to fragile, damaged or healing skin. She confirmed the facility discontinued the use of disposable premoistened cleansing cloths for resident care. The residents and staff were informed that the cloths could be provided for incontinent residents with wounds due to the disposable cloths' texture being less rough, therefore less irritating to fragile, damaged or healing skin.</p> <p>On 6/24/25 at 3:30 PM during an interview the facility's Regional Director of Operations (RDO) confirmed that corporation-wide the supply and use of disposable premoistened cleansing cloths had been suspended. She stated that the facility was not required to provide disposable premoistened cleansing cloths. She stated that if any resident had wounds they would be accommodated with disposable premoistened cleansing cloths because the washable cloths could be a rougher texture.</p> <p>On 6/24/25 at 6:25 PM, during an interview, the Administrator confirmed that she was aware of resident complaints by residents and staff regarding the discontinuation of supply of the premoistened disposable cleansing cloths. She said that on 6/10/25 during a meet and greet meeting with residents and the DON several residents mentioned their displeasure and voiced concerns regarding use of only washable cloths.</p> <p>Resident #8</p> <p>Record review of the admission Record for Resident #8 revealed that the facility admitted the resident on 5/14/25 and the resident had diagnoses of chronic obstructive pulmonary disease, Diabetes and morbid obesity, atrial fibrillation, GERD, heart failure.</p> <p>Record review of the 5 Day MDS with ARD 5/21/25 for Resident #8 revealed she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The MDS review revealed the facility assessed the resident dependent for shower/ bath activity.</p> <p>Record review of the Order Summary Report with active orders as of 6/20/25 for Resident #8 included Neopsorin Plus Pain Relief MS External Cream 3/5-10000-10 (Neomycin-Polymyxin w/Pramoxine) Apply to Buttock and groin topically one time a day.</p> <p>Resident #9</p> <p>Record review of the admission Record for Resident #9 revealed the facility admitted the resident on 5/20/25 with an initial admission dated listed as 9/09/08 with diagnoses that included paraplegia and diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the admission MDS with ARD 5/27/25 for Resident #9 revealed he had a BIMs score of 15 which indicated no cognitive impairment. The MDS review revealed the facility assessed the resident dependent for toilet hygiene and personal hygiene.</p> <p>Record review of the Order Summary Report with active orders as of 6/24/25 for Resident #9 included Clean coccyx with wound cleanser, pat dry, apply calcium alginate and cover with bordered gauze one time a day of wound care with start date 5/31/25 and Clean sacral with wound cleanser, pat dry, apply hydrogel and cover with bordered gauze one time a day for wound care with start date 6/12/25.</p> <p>Resident #14</p> <p>Record review of the admission Record for Resident #14 revealed the facility admitted the resident on 10/05/23 and the resident had diagnoses of end stage renal disease, diabetes, morbid obesity, hypertension, and dependence on renal dialysis.</p> <p>Record review of the Quarterly MDS for Resident #14 with ARD 4/14/25 revealed the residents had BIMS score of 15, which indicated no cognitive impairment. MDS review revealed the resident required dependence on wheelchair for mobility, and total dependence for toileting hygiene, shower/bathing activities.</p> <p>Record review of the Order Summary Report with active orders as of 6/24/25 for Resident #14 included Apply Nystatin Powder to rash under both breast daily until resolved one time a day with start date 2/05/25 Clean sacral with wound cleanser, pat dry, apply collagen and cover with ordered gauze one time a day for wound care with start date 6/13/25 and Give pain med 30 mins-hour (thirty minutes to an hour) prior to wound care every day shift with start date 7/10/21 and Nystatin External Powder 100000 Unit/GM (units per gram) (Nystatin(Topical)) Apply to abdominal folds and groin topically every 12 hours as needed for chaffing with start date 3/08/25. and Zinc Oxide Ointment 20% Apply to right inner thigh topically every shift for skin condition apply zinc oxide to buttock and right inner thigh with start date 12/27/24.</p> <p>Resident #20</p> <p>Record review of the admission Record for Resident #20 revealed the facility admitted the resident on 9/07/23 and the resident had diagnoses of diabetes insipidus and cerebral infarction (stroke).</p> <p>Record review of the Quarterly MDS for Resident #20 with ARD 5/13/25 revealed the resident had no BIMS and included documentation of inability to participate in BIMS, memory problem and severe impairment of cognitive skills for daily decision making.</p> <p>Record review of the Order Summary Report revealed an order dated 6/26/25 Clean right medial lower leg with wound cleanser, pat dry, apply collagen and cover with bordered gauze.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, interviews, record review and facility policy review the facility failed to provide a safe and comfortable environment for residents dependent on wheelchairs for mobility (Resident #28 and Resident #8) and failed to provide adequate clean linens for (Resident #9 and Resident #20) for four (4) of (30) sampled residents.</p> <p>Findings included:</p> <p>Record review of the facility policy Resident Rights revised and implemented on Nov. 28, 2016, revealed The resident has a right to .A safe, clean, comfortable, and homelike environment .Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; clean bed and bath linens that are in good condition .</p> <p>Resident #28</p> <p>On 6/17/25 at 1:00 PM, during an observation and interview with Resident #28 revealed both armrests on the wheelchair of Resident #28 were torn with cover material tattered with all the cushion missing from both armrests. The resident stated that the condition of the armrest aggravated him and described them as uncomfortable.</p> <p>On 6/17/25 at 1:10 PM, during an observation of Resident #28's wheelchair and interview with Registered Nurse (RN)#1 revealed RN #1 confirmed the condition of the armrest and stated, That's going to have to be replaced.</p> <p>Record review of the admission Record for Resident #28 revealed the facility admitted the resident on 1/17/25 and the resident had diagnoses of Paraplegia and Muscle weakness.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/25 for Resident #28 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>Resident #8</p> <p>On 6/18/25 at 2:10 PM, during an observation and an interview with Resident #8 revealed the left arm rest was broken off of her personalized mechanical wheelchair and laying in the seat of the chair. Resident #8 stated it was broken during a transfer using the mechanical lift approximately two weeks prior and said Certified Nurses Aide (CNA) #1 was assisting in the transfer. She said it was an accident, but she did not know why it had not been repaired. She confirmed that the facility staff was aware that it was broken and that a therapist and a man from the wheelchair company had visited her room and inspected the chair.</p> <p>On 6/19/25 at 1:50 PM, during an interview with CNA #1, she confirmed that the left armrest of the personalized mechanical wheelchair of Resident #8 was broken during chair-to-bed transfer using full mechanical lift. She stated that she reported this to the resident's nurse. She said she was not sure if the resident had been transferred into the chair since.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/25 at 11:00 AM, during an interview the Occupational Therapist Assistant (OTA)# 1 confirmed that he had been made aware that Resident #8's wheelchair arm had been broken, he couldn't recall dates but said he had inspected it and notified the company that serviced the mechanical wheelchairs who had visited and said he could fix it. He said the wheelchair was relatively new and he was not sure if the resident's insurance would pay for the repair, so he had not requested the chair be repaired. He stated that he was not aware that Resident #28's wheelchair arms were in disrepair.</p> <p>Record review of the admission Record for Resident #8 revealed that the facility admitted the resident on 5/14/25 and the resident had diagnoses of Chronic obstructive pulmonary disease and Heart failure.</p> <p>Record review of the 5 Day MDS with an ARD of 5/21/25 for Resident #8 revealed she had a BIMS score of 15, which indicated no cognitive impairment.</p> <p>On 6/24/25 at 4:15 PM, an interview with the Director of Nursing (DON) revealed she was not sure how many days Resident #8 was scheduled to get up in her wheelchair or that the resident's chair had been broken, but said that it was repaired on or after 5/20/25 and the resident had been up in her chair on 5/24/25. She stated she was not aware of damages to the armrests of the wheelchair of Resident #28.</p> <p>On 6/24/25 at 6:25 PM, an interview with the Administrator revealed she was not sure how long the wheelchair arm had been broken. She stated she had not been aware of the damaged condition of the wheelchair armrests of Resident #28. She confirmed that the residents had the right to a safe, clean, comfortable environment.</p> <p>Lack of clean linens</p> <p>On 6/17/25 at 11:45 AM, during an interview with a direct care staff member revealed that when she arrived at work for the 7:00 AM through 3:00 PM (7-3) shift on 6/15/25 there was dirty linen piled up and no clean towels or facecloth's on the hall for resident care. She reported that the CNAs went to the clean laundry room, found a large plastic tote with clean unfolded linen and divided the contents up for resident care. She stated that a housekeeper came and started washing laundry mid-morning and the first load of clean linens were not dry until after lunch. She explained that CNAs made rounds to provide incontinent care and other direct care for residents every two (2) hours throughout the day. She confirmed that not all residents received personal hygiene, such as bed bath and other care was interrupted or postponed due to lack of linens. She said that the nurses on duty were aware of the lack of linens, and she thought the nurses attempted to telephone management. She stated that she was not sure who, if anyone at the facility on 6/15/25 had a key to the Housekeeping Supervisor's office.</p> <p>On 6/17/25 at 12:35 PM observation in the supply room and an interview with RN #1 revealed she stated the facility no longer supplied disposable premoistened cleansing cloths and used washable cloth facecloth's and towels for all resident care, supplemented by disposable dry washcloths and body cleanser and body wash. She confirmed the facility had a census of 81 residents and supply of 850 ten by thirteen (10X13) inch disposable (dry) washcloths and (47) - (8) ounce and (31) four (4) ounce bottles of body wash and two (2) gallon bottles of cleanser for hair and skin.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/25 at 2:55 PM, interview with Licensed Practical Nurse (LPN) #5 revealed she stated she worked 7-3 shift on 6/15/25 and there was not adequate clean linen available to make resident's beds or give bed baths to all the residents who required assistance with personal hygiene/bathing activities. She stated that when she started to make last rounds for the shift between 1:00 PM and 2:00 PM there were no clean linens available. She stated there were no disposable premoistened cleansing cloths and described the disposable dry cloths as flimsy and easily torn. She stated the staff made do and did what they could but confirmed that resident care was interrupted and or postponed due to lack of clean linens. She stated that when she reported the need for linen she was told by nurses and housekeeping staff, We don't have it.</p> <p>On 6/17/25 at 4:50 PM, during an interview with CNA#6 and CNA#7 revealed CNA #6 reported she had worked 6/15/25 and that lack of adequate linens was a problem which caused postponement and interruption of resident care, including bathing/showering activities. Both stated that the facility only having one sit-to-stand lift, and one full-body lift caused postponement and interruption of resident care, including bathing/showering and surface-to-surface transfers. They explained that so many residents on North Unit preferred to get washed up and get up into their wheelchairs, requiring a mechanical lift before 7:00 AM, and that so many of the residents were very large and/or totally dependent and required two person assistance for bed mobility, incontinence care, bathing activities and transfers there was no way to accommodate preferences. They both stated that dialysis patients had priority to make sure they were prepared and up for transfer to dialysis appointments. Both reported that it was physically impossible for either lift to be employed by the South Unit staff for resident transfers and North Unit transfers, which resulted in some residents' care being postponed or interrupted while staff waited for a lift to become available.</p> <p>On 6/19/25 at 4:10 PM, during an interview Registered Nurse (RN)# 3 reported that she was on duty on the 7:00 AM through 3:00 PM (7-3) shift and there were not adequate towels or facecloth's for residents' care available. She confirmed that the lack of adequate quantity of towels and facecloth's cause an interruption and postponement of resident care throughout the shift. She confirmed she texted the housekeeping supervisor at approximately 9:18 AM on 6/15/25 and notified her of a lack of linens for resident care. She confirmed that an on-duty housekeeper responded mid-morning and began washing dirty linens.</p> <p>On 6/20/25 at 11:05 AM, during an observation and an interview with the Housekeeping Supervisor revealed that she explained that the door diagonally across from the North Unit Nurses' Station designated with a Clean Linen sign on the door was not the clean linen storage. She explained that clean linen storage had been moved to the laundry room mid-way between North and South Units. She was not able to explain why all nursing staff had indicated the room with the Clean Linen sign as the clean linen storage room for two (2) days. She said the clean linen closets were being changed to storage rooms. She then took a piece of plain white paper and wrote Supply Room on it and taped it over the Clean Linen sign. She stated the facility always had plenty of clean linen. The Housekeeping Supervisor stated that the situation that occurred on 6/15/25 was a result of miscommunication between her and Laundry Aide #1, who had notified her on the evening of Saturday, 6/14/25 that she was calling in for Sunday, 6/15/25. She said she thought Laundry Aide #1 meant Monday, 6/16/25. She stated that she had received a text from RN #3 at 9:18 AM on 6/15/25 that said the facility needed clean linen. She stated that she notified a housekeeper that she needed her to go to the laundry immediately and that the housekeeper went to the laundry at 10:30 AM. She confirmed that she was aware that the residents needed clean linens, specifically washcloths and towels for incontinence care, bathing/shower activities, personal hygiene during AM care prior to 10:30 AM and throughout the morning and day.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/25 at 11:30 AM, during an observation and interview Resident #8 confirmed that she had been told by staff that care was postponed due to lack of clean linens. She stated that she had not been assisted to get up for at least two weeks and could not recall the last date she was assisted into her wheelchair. She stated that staff routinely told her she would have to wait for care, including showers and surface-to-surface transfers. She stated, If there are three people working and it takes two to get me up, I have to wait if two of them are with someone else.</p> <p>Resident #9</p> <p>On 6/23/25 at 2:00 PM, during an interview Resident #9 confirmed that he had voiced complaints regarding postponement and lack of care on 6/15/25 because he did not receive a bed bath or what he considered sufficient incontinence care and was told by the CNA (could not recall name) that the reason was that there were no clean linens. He said that he could not get sufficient incontinence care because of lack of linens and no disposable wipes. He said he was aware that the facility was not required to supply disposable cleansing cloths but was told that if residents with wounds requested them, they would be provided. He said he had told multiple staff that he preferred the disposable wipes for incontinence care due to the rough texture of the washable washcloths and the fragility of his skin, but none had been provided for him. He said that he did not get care in a timely manner on 3:00 PM to 11:00 PM (3-11) shift or the 11:00 PM to 7:00 AM (11-7) shifts and had to wait for bed baths, showers and to get out of bed routinely and was told that he had to wait because there were only two (2) CNAs scheduled and he required at least two (2) staff for bed mobility (to turn/reposition while in bed) and for bed/chair-to-chair transfers with mechanical lift. He said that sometimes he was told that he had to wait because the lift was not available because it was being used on the South Unit. He stated that it seemed to him that the facility had stopped being for the residents and was being run for the convenience of the staff. He said he did not understand why the facility could not provide disposable cleansing cloths or enough lifts for the staff to provide adequate care for the residents. He described the dry disposable wipes as a joke, not good for nothing; too flimsy.</p> <p>Record review of the admission Record for Resident #9 revealed the facility admitted the resident on 5/20/25 with an initial admission dated listed as 9/09/08 with diagnoses that included paraplegia and diabetes.</p> <p>Record review of the admission MDS with an ARD 5/27/25 for Resident #9 revealed he had a BIMS score of 15 which indicated no cognitive impairment. The MDS review revealed the facility assessed the resident dependent for toilet hygiene and personal hygiene.</p> <p>Resident #20</p> <p>On 6/23/25 at 9:08 PM, during an interview, Contact #1 for Resident #20 revealed the family had been supplying disposable premoistened cleansing cloths for the care of Resident #20 because his lack of mobility contributed to skin issues and the washable cloths (face cloths and towels) had a rougher texture. She stated that her only complaint was that the facility had stopped providing disposable premoistened cleansing cloths for the care of Resident #20.</p> <p>Record review of the admission Record for Resident #20 revealed the facility admitted the resident on 9/07/23 and the resident had diagnoses of Diabetes insipidus and Cerebral infarction (stroke).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pleasant Hills Com LIV Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Quarterly MDS for Resident #20 with ARD 5/13/25 revealed the resident had no BIMS and included documentation of inability to participate in BIMS, memory problem and severe impairment of cognitive skills for daily decision making.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure Resident #1's right to be free from abuse when the facility failed to prevent repeated resident-to-resident physical aggression between Resident #1 and Resident #2. This resulted in Resident #1 sustaining periorbital edema and redness to the left eye, causing Resident #1 pain that required analgesic (pain) medication for two (2) of (30) sampled residents. Resident #1 and Resident #2.</p> <p>Findings included:</p> <p>Record review of the facility policy Resident Abuse or Neglect Prevention Plan dated March 15, 2004, revealed, The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion .Guideline: Theses requirements specify the right of each resident to be free from abuse .and the facility's responsibilities to prevent not only abuse, but also those practices .that if left unchecked, lead to abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents</p> <p>Record review of the Facility Investigation dated 6/20/25 with an attached statement by Licensed Practical Nurse (LPN) #1 revealed On June 9, 2025, nurse reported to writer that resident 4918 punched resident 4864 in face at drink machine. Certified Nursing Assistant (CNA) witnessed incident take place. Administrator notified.</p> <p>On 6/18/25 at 7:35 PM, during a telephone interview LPN #1 revealed that she was made aware of an allegation of abuse of Resident #2 by Resident #1 on 6/09/25. She said CNA #5 reported to her that she witnessed Resident #1 punch Resident #2 in the face. She said she couldn't recall if an incident report was completed. She confirmed that the two residents professed to be in a relationship, but staff had discouraged the relationship due to on-going abusive behavior by both residents toward each other and the two residents sought each other out regardless of room assignments. She stated that hourly monitoring/supervision had not proven successful as incidents happened so suddenly.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 2:50 PM, during an interview the Social Services Director, (SSD) confirmed she was the official Grievance Officer of the facility and stated that she made the Administrator aware of all credible allegations and all allegations of abuse and neglect. She stated her role in any allegation of abuse would be to offer counseling and support and send in referral to in-facility contracted psychiatric services (including psychosocial therapist and psychiatric Nurse Practitioner) to any victim and perpetrator in the case of resident-on-resident incidents. She said the contracted psych services visits weekly. She confirmed she had been made aware of several allegations of resident-on-resident abuse between Resident #1 and Resident #2 and had referred both to in-facility contracted services and outpatient and inpatient services as a result. She stated that Resident #1 was transported by the facility to outpatient services and she was awaiting response for referral for Resident #2 for inpatient services following an incident witnessed earlier in the day in which Resident #2 slapped Resident in the face with her hand and hit his left eye with a cellular telephone. She confirmed that there was an incident on or around 3/04/25, another on or around 5/30/25, another on 6/09/25, and another on 6/19/25. The SSD confirmed that discharge planning was underway for Resident #1 with referrals pending to more independent living facilities, and the process included obtaining a birth certificate for identification purposes for approval by the other facilities. She said she was awaiting postal delivery of his birth certificate to move to the next step. She said Resident #1 had recently been diagnosed with cancer and the facility was involved in providing services related to the diagnoses that included transportation to appointments.</p> <p>On 6/19/25 at 4:10 PM, during an interview Registered Nurse (RN) #3 reported that on 6/09/25 she exited the facility through the Business Office Entryway and was getting into her vehicle at approximately 11:49 PM after clocking out and CNA #5 was seated in a chair outside of the door. She stated that CNA #5 stood up to open the door and immediately turned and told her Resident #1 hit Resident #2. RN #3 said she instructed CNA #5 to go in and immediately notify the nurse and RN #3 called LPN#4 from her cell phone and reported the incident to LPN #4.</p> <p>On 6/19/25 at 5:30 PM, an interview with CNA #5 revealed that on 6/09/25 she had worked 3-11 shift and at approximately 11:40 PM she was going inside the Business office entrance and observed through the door window Resident #1 strike Resident #2. She said she reported immediately to RN #3, who was off duty, removed Resident #2 to the South Unit. CNA #5 said that Resident #2 was on hourly visual checks to ensure her whereabouts and safety due to previous allegations of her abuse by Resident #1.</p> <p>On 6/20/25 at 2:30 PM, during an interview CNA#4 revealed he had worked 7-3 on 6/19/25 and after lunch he was leaving room [ROOM NUMBER]B and observed Resident #2 slapping Resident #1 multiple times. He stated that he immediately went to get between the two and separate them and Resident #2 stood from her wheelchair and struck Resident #1's left eye with her cellular telephone (right hand). CNA #4 reported that Resident #2 continued fighting to get to Resident #1 and it took three (3) staff to calm the residents. He stated he had observed Resident #2 acting in an aggressive manner towards others, both staff and residents, prior to 6/19/25. He said that he had been made aware of acts of aggression between the two (2) residents when Resident #2 was transferred from North Unit to South Unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Progress Notes for Resident #1 revealed that 3/4/2025 11:59 (AM) Behavior Note Note Text: res (resident) informed writer that he and (Resident #2) had an altercation over a bag of candy. The bag remained in the resident's possession and after not returning it, she was upset. She started hitting me and was warned to stop, resident continued and (Resident #1) hit other residents in the face. Both residents were informed to stop causing issues with one another and agreed to do so. And 5/30/2025 20:35 (8:35 PM) Behavior Note Note Text: Resident 1 was accused of physical assault on Resident 2 in the bedroom of Resident 1. Resident 2 was visibly shaken and in distress when brought to the nurses station. Resident 1 was asked about the incident that supposedly took place he denied physically assaulting but yelling at her in a threatening manner. Resident stated he was going to have a talk with her. Resident was advised not to contact Resident 2, Resident 1 appeared to be agitated and dismissive. Writer will continue to monitor Resident 1 for the remainder of the shift. Writer consoled Resident 2 and reassured her safety for the remainder of the shift. Administrator notified immediately currently awaiting further instructions. There was no documentation of allegation against Resident #1 of the abuse of Resident #2 on 6/09/25. Progress Notes review revealed 6/19/2025 19:13 (7:13 PM) Incident Note Note Text: REPORTED BY ADMINISTRATOR THAT AT APPROXIMATELY 1330PM RESIDENT #4864 (Resident #2) HIT RESIDENT #1697 (Resident #1) WITH A CELL PHONE ON THE LEFT SIDE OF HEAD NEAR EYE AND ALSO HIT RESIDENT WITH HAND ON RIGHT SIDE OF HEAD NEAR EYE. NO DISCOLORATIONS, OPEN AREA OR ABRASIONS NOTED. REDNESS TO SCLERA NOTED TO OUTSIDE CORNER OF LEFT EYE. NO C/O HEADACHE OR BLURRY VISION. RESIDENT REPORTS AREA SORE. RESIDENT PLACED ON EVERY HOUR LOCATION MONITORING and 6/19/2025 18:01 (6:01 PM) Social Services Note Text: Resident reports that his face is hurting because his lady friend hit him with her cell phone. Incident reported to admin.</p> <p>On 6/20/25 at 11:45 AM, observation and interview revealed Resident #1's left eye had noticeable periorbital edema (swelling around eye) and redness of the sclera (white part of the eyeball). Resident #1 stated that on the afternoon of 6/19/25, Resident #2 slapped him on the right side of his face and hit him with a cellular telephone at the outer corner of his left eye. He stated it hurt at the time and into the evening and he had pain medication administered which controlled the pain. He said he did not know why she struck him, that they had been sitting near each other talking, he stated, she does that, she just all of the sudden starts hitting me.</p> <p>On 6/20/25 at 5:20 PM, during an interview with Resident #2 in her room revealed she was in a relationship with Resident #1 and confirmed she hit him and described hitting him as playing with him. She said that Resident #1 had not hit her. Her demeanor was giddy and friendly. The State Agency (SA) was unable to determine if Resident #2 had adequate memory to recall past events or only recent events.</p> <p>On 6/24/25 at 4:15 PM, during an interview with the Director of Nursing (DON) revealed the facility was aware of the on-going incidents of aggression and combativeness by and between Resident #1 and Resident #2. She said SSD was working with Resident #1 to find more independent living placement and Resident #2 was currently at an inpatient psychiatric care facility. She stated she had not considered one-on-one supervision of either resident to ensure residents' safety. She said Resident #2 had been transferred to different rooms twice, but the residents continued to seek each other out for interaction and the facility's position was that they had the right to visit with each other if they chose.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 at 6:25 PM, during an interview with the Administrator she stated she was aware of the on-going incidents of aggression and combativeness between Resident #1 and Resident #2. She confirmed the SSD was working with Resident #1 to find more independent living placement and Resident #2 was currently at an inpatient psychiatric care facility. She stated she had not considered one-on-one supervision of either resident to ensure residents' safety. She confirmed Resident #2 had been transferred to different rooms twice, and the residents continued to seek each other out for interaction and the facility's position was that they had the right to visit each other if they chose. She confirmed that the facility policy provided for provision of a safe environment, free from abuse.</p> <p>Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 11/04/24 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction (stroke) and Diabetes.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/08/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>Record review of the admission Record for Resident #2, revealed the facility admitted the resident on 1/19/24 with diagnoses that included Chronic kidney disease and Heart failure.</p> <p>Record review of the Annual MDS with an ARD of 6/19/25 for Resident #2 revealed she had a BIMS score of 14, which indicated no cognitive impairment. The MDS review revealed the resident displayed physical symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing) behavior and verbal behavior symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) 1 to 3 days during assessment period which put the resident at significant risk for physical illness or injury and Put others at significant risk of physical injury.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, and facility policy review, the facility failed to report an allegation of resident-on-resident physical abuse to the State Agency (SA) within the required timeframe for one (1) of four (4) reviewed allegations of abuse. Resident #1. Specifically, an allegation made on 6/09/25 that Resident #1 physically abused Resident #2 and was witnessed and reported by Certified Nursing Assistant (CNA) #5. This was investigated internally by the facility but not reported to the SA as required by federal regulations.</p> <p>Findings Included:</p> <p>Record review of the facility policy titled, Reporting Alleged Abuse or Neglect to State Agencies dated November, 1, 2004, revealed, It is the policy of this facility that persons employed in facilities owned or managed by this facility with knowledge of or a reasonable cause to believe that any patient or resident has been the victim of abuse, neglect, or mistreatment must report or cause a report to be made to the appropriate state agencies as prescribed by the laws of that state .</p> <p>On 6/18/25 at 1:13 PM, during an interview with Resident #1 in his room he confirmed there was an altercation between himself and Resident #2 near the vending machines on the evening of 6/09/25. Resident #1 stated that Resident #2 was slapping at his face and he caught her arm mid-swing and threw it back, hitting her face.</p> <p>On 6/18/25 at 7:35 PM, during a telephone interview Licensed Practical Nurse (LPN) #1 revealed that she was made aware of an allegation of abuse of Resident #2 by Resident #1 on 6/09/25. She said Certified Nursing Assistant (CNA)#5 reported to her that she witnessed Resident #1 punch Resident #2 in the face. She said she couldn't recall if an incident report was completed.</p> <p>On 6/19/25 at 2:50 PM, an interview with the Social Services Director, (SSD) confirmed she was the official Grievance Officer of the facility and stated that she made the Administrator aware of all credible allegations and all allegations of abuse and neglect. She confirmed that on or around 6/10/25 she was made aware of an allegation that occurred on 6/09/25. This was an incident of physical abuse of Resident #2 by Resident #1 in which CNA #5 reported that Resident #1 punched Resident #2 in the face. She confirmed that she had received the report that Resident #1 had said he took Resident #2's hand and made her hit herself in the face.</p> <p>On 6/19/25 at 4:10 PM, during an interview Registered Nurse (RN) #3 reported that on 6/09/25 she exited the facility through the Business Office Entryway and was getting into her vehicle at approximately 11:49 PM after clocking out and CNA #5 was seated in a chair outside of the door. She stated that CNA #5 stood up to open the door and immediately turned and told her that Resident #1 had hit Resident #2. RN #3 said she instructed CNA #5 to go in and immediately notify the nurse. RN #3 called LPN #4 from her cell phone and reported the information to LPN #4.</p> <p>On 6/19/25 at 5:25 PM, the SA attempted to contact the Resident Representative (RR) for Resident #2 without success. There was not an option to leave a message.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 5:30 PM, during an interview CNA #5 revealed that on 6/09/25 she had worked 3-11 shift and at approximately 11:40 PM she was going inside the Business Office entrance and observed through the door window Resident #1 strike Resident #2. She said she reported immediately to RN #3, who was off duty, removed Resident #2 to the South Unit and reported to LPN #4. She said that Resident #2 had been crying and had said on the evening of 6/09/25 that Resident #1 hit her.</p> <p>Record review of the Progress Notes for Resident #1 revealed that there was no documentation of any allegations against Resident #1 of the abuse of Resident #2 on 6/09/25. A progress note was dated with an effective date of 6/20/25 at 5:51 PM that addressed the incident that occurred on 6/9/25.</p> <p>Record review of Facility Investigation with Date of incident documented as 6/09/25 revealed the facility conducted interviews and investigation beginning 6/09/25 into an incident described as Resident on Resident (abuse).</p> <p>On 6/20/25 at 5:20 PM, an interview with Resident #2 in her room revealed she stated she was in a relationship with Resident #1 and confirmed she hit him and described hitting him as playing with him. She said that Resident #1 had not hit her. Her demeanor was giddy and friendly. The SA was unable to determine if Resident #2 had adequate memory to recall past events or only recent events.</p> <p>On 6/24/25 at 4:15 PM, during an interview the Director of Nursing (DON) revealed the facility was aware of the on-going incidents of aggression and combativeness by and between Resident #1 and Resident #2. She said the SSD was working with Resident #1 to find more independent living placement and Resident #2 was currently at an inpatient psychiatric care facility. She stated she had not considered one-on-one supervision of either resident to ensure residents' safety. She said Resident #2 had been transferred to different rooms twice, but the residents continued to seek each other out for interaction and the facility's position was that they had the right to visit with each other if they chose.</p> <p>On 6/24/25 at 6:25 PM, during an interview the Administrator revealed that on 6/10/25 she was made aware of an allegation of physical abuse of Resident #2 by Resident #1 on 6/09/25. She stated that she had not reported the allegation because of the ongoing incidents between the two residents and because during interview Resident #2 denied being struck by Resident #1. She confirmed that staff had reported Resident #1 crying following an interaction with Resident #1 near the vending machines on the evening of 6/09/25.</p> <p>Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 11/04/24 and the resident had diagnoses of Hemiplegia and hemiparesis following cerebral infarction (stroke) and Diabetes.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/08/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>Record review of the admission Record for Resident #2 revealed the facility admitted the resident on 1/19/24 and the resident had diagnoses of Chronic kidney disease and Heart failure.</p> <p>Record review of the Annual MDS with an ARD of 6/19/25 for Resident #2 revealed she had a BIMS score of 14, which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Quarterly MDS for Resident #2 with an ARD 3/19/25 revealed the resident had a BIMS score of 9, which indicated moderate cognitive impairment.		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide personal hygiene, specifically fingernail and toenail care during Activities of Daily Living (ADL) care for two (2) of (29) residents reviewed: Resident #18 and Resident #28.</p> <p>Findings included:</p> <p>A review of the facility's policy, A.M. Care, with a revision date of August 25, 2014, revealed, RESPONSIBILITY: Licensed Nurse, Certified Nursing Assistant .PURPOSE .2. To provide cleanliness, comfort and neatness .4. To assess the resident's condition. 5. To assess the resident's needs . EQUIPMENT .Care of nails .</p> <p>Resident #18</p> <p>On 6/17/2025 at 12:50 PM, during an observation in the North Unit Day Room/Dining Room, Resident #18 was seated in his wheelchair with ten (10) long fingernails with a black substance under each nail. All fingernails extended past the ends of his fingers three-sixteenths (3/16) of an inch (comparable to three stacked dimes) to one-third (1/3) of an inch (comparable to four stacked dimes). Resident #18 stated that he wished they would cut them. Resident #18 then removed his right shoe and indicated that he wished to have his toenails trimmed also. The second and third (middle) toe on his right foot both measured approximately one-third (1/3) of an inch past his toes.</p> <p>A record review of the admission Record for Resident #18 revealed the facility admitted the resident on 4/25/2023. The resident had diagnoses of Chronic Obstructive Pulmonary Disease and Alzheimer's Disease.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 6/17/2025 revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of five (5), which indicated severe cognitive impairment.</p> <p>Resident #28</p> <p>On 6/17/2025 at 12:50 PM, during an observation in the same room, Resident #28 was seated in the back left corner. He raised his hand and stated that he needed his fingernails cut. Observation revealed Resident #28 had ten (10) long fingernails with a black substance under each nail. All fingernails extended past the ends of his fingers three-sixteenths (3/16) of an inch (comparable to three stacked dimes) to one-third (1/3) of an inch (comparable to four stacked dimes).</p> <p>A record review of the admission Record for Resident #28 revealed the facility admitted the resident on 1/17/2025 with diagnoses that included Paraplegia and Muscle Weakness.</p> <p>A record review of the Quarterly MDS with ARD 3/31/2025 for Resident #28 revealed the resident had a BIMS score of fifteen (15), which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pleasant Hills Com LIV Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Raymond Rd Jackson, MS 39204	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/2025 at 1:00 PM, during an observation and an interview with Registered Nurse (RN) #1, she confirmed that both residents' fingernails and toenails were observed during weekly body audits and that any licensed nursing personnel could trim fingernails or toenails. She stated that a list was maintained for residents who needed toenail care, which was provided by the contracted podiatrist who visited the facility routinely. Observation revealed the facility had adequate supplies for fingernail and toenail care in the supply closet on the North Unit.</p> <p>On 6/24/2025 at 4:15 PM, during an interview the Director of Nursing (DON), confirmed that nail care was included in ADL care and that any licensed nursing staff could trim fingernails or toenails for residents.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review, interviews and facility policy review, the facility failed to evaluate and analyze hazards and risks and failed to assess a resident following a documented fall for one (1) of three (3) residents with documented falls: Resident #27.</p> <p>Findings included:</p> <p>A review of the facility's policy, Falls, with a revision date of September 28, 2012, revealed, .If a fall occurs: 1. Incident and Accident report is to be filled out at the time of the fall and reviewed in standup/morning meeting and addressed on the 24 hour report. 2. Documentation is initiated at the time of the fall and continues, at a minimum, of every shift for three (3) days or until the condition stabilizes. 3. Fall investigation and Supervisor Report is to be completed. 4. Resident history of falls is an ongoing document (do not start one each month). This is to be completed with each fall and kept in a notebook. 5. Care plan and ADL(activities of daily living) Care Plan need to be updated with each fall. 6. All these forms need to be compiled at the end of the three days of documentation and kept together and the fall recorded on the event log. a) I/A (incident and accident) report. b) Fall Investigation/Supervisor. C.) Report Any statements .</p> <p>Record review of Progress Notes *NEW* dated 5/12/2025 revealed Note Text: Nurse went to check on resident after being informed of fall in bathroom by aides while his nurse was absent. Resident was conscience and was in no danger at the time. Reported to staffing coordinator.</p> <p>On 6/18/2025 at 7:35 PM, during a telephone interview with Licensed Practical Nurse (LPN) #1, she stated that she did not remember a fall by Resident #27 on 5/12/2025. She explained that there were times when disagreements occurred among staff regarding who was responsible for documenting incidents involving residents.</p> <p>On 6/20/2025 at 1:00 PM, during an interview with the Staffing Coordinator, she stated she was responsible for facility staffing and occasionally filled in as a direct care nurse. She reported that she did not recall a fall by Resident #27 being reported to her on 5/12/2025.</p> <p>On 6/24/2025 at 4:15 PM, during an interview with the Director of Nursing (DON), she explained that in the event of a fall, the resident's nurse or licensed nursing staff should be notified to assess the resident prior to transferring them from the floor. If the nurse determined the resident was unharmed, staff should assist the resident off the floor. A body audit should be performed by a licensed nurse, and the resident's primary healthcare provider and Responsible Party (RP) should be notified. An incident report should be completed with ongoing documented assessment for the following seventy-two (72) hours, including vital signs each shift. The DON stated that completing the incident report was important to help determine the cause of the fall, prevent future falls, and identify any changes in the resident's condition. She noted that she was conducting in-service training to ensure all staff were aware of the protocol and stated she was unaware of any falls prior to her employment in June 2025. She was not able to provide documentation of an incident report or follow-up monitoring related to Resident #27's 5/12/2025 fall.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/2025 at 6:25 PM, during an interview with the Administrator and a review of the medical record for Resident #27, the Administrator was not able to locate or provide documentation of an incident report related to the fall that occurred on 5/12/2025, which had been documented in the Progress Notes. She confirmed that she expected licensed nursing staff to provide and document an adequate assessment for residents following a fall.</p> <p>A record review of the admission Record for Resident #27, revealed the facility admitted the resident on 5/10/2024. The resident had diagnoses of Paranoid Schizophrenia, Muscle Weakness, Altered Mental Status, and a need for assistance with personal care.</p> <p>A record review of the Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/24/2025 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, record review, interviews and facility policy review, the facility failed to safely and securely store medications for one (1) of thirty (30) sampled residents: Resident #8.</p> <p>Findings included:</p> <p>A review of the facility's policy, Medication Storage in the Facility, with a revision date of December 27, 2006, revealed, Storage of Medications Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . 4. Bedside Storage of Medications: Bedside medications storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber .</p> <p>On 6/20/2025 at 11:30 AM, during an observation and interview with Resident #8, two (2) vials of Albuterol Sulfate Inhalation Solution 0.5-2.5 (3) MG/3ML(milligrams/milliliter), (Ipratropium-Albuterol) were observed on the resident's overbed table. One vial was opened and one vial was unopened. The resident stated that the nurses brought them to her and left them. She added that she thought there were more somewhere, but was unable to locate them. Observation revealed there was no individual medication storage cabinet inside the resident's room.</p> <p>On 6/20/2025 at 4:15 PM, during an interview the Director of Nursing (DON), stated that she was not aware that Resident #8 had medications stored unsecured in her room.</p> <p>On 6/24/2025 at 6:25 PM, during an interview with the Administrator, she confirmed that all medications were expected to be stored safely and securely in locked medication rooms or locked medication carts.</p> <p>A record review of the admission Record for Resident #8 revealed the facility admitted the resident on 5/14/2025. with diagnoses that included Chronic Obstructive Pulmonary Disease, Diabetes, and Heart Failure.</p> <p>A record review of the Five-Day Minimum Data Set (MDS) with Assessment Reference Date (ARD) 5/21/2025 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated no cognitive impairment.</p> <p>A record review of the Order Summary Report with active orders as of 6/20/25 revealed a physician order dated 1/22/2025 Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3 ml inhale orally every four (4) hours related to Acute Respiratory Failure with Hypoxia (J96.01). Please give the 0000 dose at 2300. Document breath sounds, duration, sputum, toleration in nebulizer assessment. There was no physician order for the storage of medications in the resident's room.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on observation, record review, interview, and facility policy review the facility failed to assess the resident population and identify resources needed to provide necessary day-to-day care and services for residents. The facility failed to evaluate the overall number of facility staff and mechanical lifts needed to ensure sufficient staff and equipment were available to meet residents' needs based on residents' assessments for (30) of (30) sampled residents with the potential to affect all residents.</p> <p>Findings included:</p> <p>A review of the facility's policy, Facility Assessment, with a review date of January 2023, revealed, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations .1. Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure that the resources are available to meet the specific needs of our residents . 3. The facility assessment includes a detailed review of the resources available to meet the needs of the resident population. This part of the assessment includes . 4.b. Equipment and supplies (medical and non-medical) . 4.e. All personnel .6. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed .</p> <p>A review of the facility's policy, Staffing, with a review date of October 2022, revealed, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .</p> <p>A review of the facility assessment revealed the assessment did not include any information regarding the number of staff needed or the number of mechanical lifts required to meet the needs of residents.</p> <p>On 6/20/2025 at 1:00 PM, during an interview with the Staff Development Coordinator (SDC), she stated that she was responsible for facility staffing and occasionally filled in as a direct care nurse. She explained that she did not utilize the facility assessment for scheduling staff and was not sure what it was. She stated she scheduled staff using PPD (per patient day) and had not assessed the two units separately for resident acuity or daily care needs. She acknowledged that the North Unit was heavier, meaning it had more dependent residents and more residents with diagnoses of Morbid Obesity, which she confirmed required additional staff to assist with bed mobility, incontinence care, and bathing/showering activities.</p> <p>On 6/24/2025 at 5:00 PM, during an observation and interview with the Director of Nursing (DON) and Administrator, it was revealed that the facility had one (1) functional full-body lift and one (1) functional sit-to-stand lift.</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/2025 at 6:25 PM, during an interview with the Administrator, she confirmed that if the direct care staff were using a lift on either unit, residents on the other unit would have to wait to get into or out of bed or to receive transfers. This could delay care such as showers or incontinence care. She confirmed that the number of lifts needed to provide timely resident care was not addressed in the facility assessment. She also confirmed that staffing levels necessary to meet resident care needs in a timely manner were not addressed in the facility assessment.</p>		