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	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hills Community Living 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, interviews and facility policy review, the facility failed to properly secure a wheelchair security device and prevent accidents for residents who depended on the facility van and staff for transfers to medical appointments for one (1) of three (3) sampled residents. Resident #1. Findings Included:Record review of the facility of the facility policy Accidents/Incidents (undated) revealed .Purpose: To assure that all persons who are involved in an incident or accident, or suspected to have had an incident or accident, are evaluated and receive treatment as indicated and are monitored for disposition of incident and accident .Record review of the incident report dated 1/08/26 for Resident #1 revealed the incident was described as . while in route to Dr. Appointment, resident fell backwards in wheelchair and hit the back of her head causing a small hematoma (area of trauma where blood vessels broke and blood pooled beneath the skin).Record review of the Facility Investigation dated 1/08/26 revealed Resident #1 .was on the transportation van on her way to an appointment when her (wheel)chair fell backwards and she hit the back of her head on the floor causing a hematoma to form. Certified Nursing Assistant (CNA) #1 and CNA #2 went to the back of the van and they both assisted (Proper name of Resident #1) getting up.CONCLUSION: (Proper name of Resident #1) was strapped in but (Proper name of CNA #1 transportation assistant, failed to ensure that the wheelchair straps were appropriately placed to firmly secure the chair resulting in the chair rolling backwards.Record review of the hospital After Visit Summary dated 1/08/26 for Resident #1 revealed the resident was seen at the local hospital emergency department for Fall.Injury of head and based on radiography X-Ray and computed tomography (CT) scans the resident had no new diagnoses or orders. Documentation indicated the resident was treated with an over-the-counter analgesic.Record review of the Quality Assurance and Performance Improvement (QAPI) committee meeting document with attached signature sheet dated 1/08/26 revealed the facility QAPI committee determined the root cause of the fall experienced by Resident #1 on 1/08/26 was Root Cause: The primary cause of the fall was that the resident's wheelchair was not properly secured with appropriate straps to maintain a stable and secure position during transportation. On 2/23/26 at 11:00 AM, during an interview CNA #1 revealed that on 1/08/26 during transportation for Resident #1, she used four (4) hooks to secure the frame of the wheelchair using the facility van's resident securement system. She stated the wheelchair was attached to the floor of the van. She stated that during transport of the resident to a physician's appointment at a local hospital at approximately 8:10 AM, she heard a noise in the van and looked in the rear of the van and saw Resident #1 on the van floor with her wheelchair turned over on its side, and the seatbelt was no longer secured over (or around) the resident. She stated that the resident had come out of the chair. She said that she and CNA #2 asked the resident how she was and the resident responded, I hit my head and reported head pain. She said she and CNA #2 picked the wheelchair up and assisted the resident back into the chair and then telephoned the Administrator and told (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	her that the resident had fallen over in her wheelchair on the van during transport and hit her head. She stated that the Administrator instructed them to take her to the same hospital, but to the emergency department for assessment. She explained that the attachment on the driver's side had come loose.On 2/23/26 at 11:20 AM, during an interview CNA #2 revealed she and CNA #1 on 1/08/26 at approximately 8:00 AM assisted Resident #1 onto the facility van's and secured the resident's wheelchair using the resident securement system, but that she had not observed or used any checklist to ensure correct or proper securement. She said that as she drove Resident #1 to a physician's appointment at a local hospital, she heard a noise in the back of the van and observed Resident #1 on the floor of the van and her wheelchair turned over on its side. She stated after parking the van she and CNA #1 asked the resident if she was ok and the resident responded by saying her head hurt and that she had hit her head. CNA #2 confirmed that she and CNA #1 had turned the wheelchair upright and assisted the resident into the wheelchair and then called the facility Administrator who instructed them to continue to the hospital but to take the resident to the emergency department instead of the physician's office. She confirmed that she and CNA #1 had returned to the facility where the Maintenance Supervisor had inspected the resident securement system and determined that all components were intact and functioning correctly.On 2/23/26 at 12:00 PM, during an interview the Administrator revealed she had been notified shortly after 8:10 AM on 1/08/26 by CNA #1 that during transportation via facility van, Resident #1's wheelchair had fallen over, and the resident had hit her head. The Administrator confirmed that CNA #1 informed her that she and CNA #2 had asked the resident if she was ok and the resident reported she had hit her head and her head hurt. The Administrator stated that if the transportation staff had called her prior to moving the resident, she would have instructed them to stay put and call emergency services to come to them so qualified personnel could evaluate and assess Resident #1 prior to moving the resident. The Administrator confirmed that the facility QAPI committee met on 1/08/26 and reviewed the incident and determined that the root cause of the fall was that the resident's wheelchair was not properly secured by facility staff with appropriate straps to maintain a stable and secure position during transportation. She stated that all staff involved in transportation of residents in the facility van were in-serviced on the resident securement system and fall policy regarding appropriate assessment and evaluation of residents by appropriately licensed prior to moving the residents following a fall or accident.On 2/23/26 at 3:15 PM, during an interview the Maintenance Supervisor stated that upon returning the van to the facility following the transport of Resident #1 he had inspected the facility van resident securement system and found all the components of the system intact and functioning correctly. He stated that he was not involved with training staff regarding procedures for falls because nursing staff were responsible for that part of the training.Record review of the admission Record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, heart failure and rheumatoid arthritis.Record review of the Significant Change Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 12/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Section GG indicated Resident #1 required a wheelchair for mobility.