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	12/12/2024

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. 47873 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents' rights were followed related to respect and dignity when a Certified Nurse Aide (CNA) attempted to check a resident for incontinence in the hallway and against his wishes (Resident #7) and failed to have a privacy cover on a urinary drainage bag (Resident #79) for two (2) of 19 sampled residents. Findings included: A review of the facility's Resident Rights policy, dated 07/24/2023, revealed, Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation .1 .These rights include the right resident's right to .b. be treated with respect, kindness, and dignity . Resident #7 On 12/09/2024 at 10:10 AM, during an interview, Resident #7 reported that while he was listening to a church service on 10/27/2024 around 10:00 AM, CNA #1 approached him in the hallway and attempted to check for incontinence. The resident stated that the CNA began pushing his wheelchair down the hall, prompting him to lock the wheels to stop her. He claimed that she then attempted to look inside his pants, leading him to hold his pants and tell her, Leave me alone. He further stated that CNA #1 left, stating she would get another staff member as a witness, and he returned to the church service. There were no other interactions with the CNA. On 12/11/2024 at 10:10 AM, during an interview, CNA #1 acknowledged the incident and stated she recognized after the fact that her actions, including attempting to check the resident's brief against his wishes, were inappropriate. She stated it was close to the end of her shift, and she was trying to make sure all her residents were taken care of before shift change. She further stated it was not her intention to upset the resident, she was just trying to take care of him. On 12/12/2024 at 8:10 AM, during an interview, Licensed Practical Nurse (LPN) #3 confirmed that on 10/27/24, Resident #7 was outside the dining room window listening to the church service. She stated that CNA #1 attempted to assist the resident but that he declined care, stating he preferred to wait until 2:30 PM. (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

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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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/2024 at 10:25 AM, during an interview, the Licensed Nursing Home Administrator (LNHA) corroborated that CNA #1 attempted to assist Resident #7 on 10/27/24, who had requested to delay care until later. A record review of the Admission Record revealed the facility originally admitted Resident #7 on 6/18/2024 and he had a current diagnosis of Paraplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/2024 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of a Behavior Note, dated 10/27/24 at 2:32 PM, revealed the CNA was attempting to check the resident for incontinence and the resident told her to Go on now. A record review of a Grievance/Concern Decision Report, dated 11/4/24, revealed Resident #7 filed a grievance against the CNA and alleged the CNA was attempting to check him for incontinence in the hallway and he told her to go on and he would return to his room for care at 2:30 PM. Corrective action included that CNA will no longer be assigned to the resident and the District Ombudsman was contacted. Resident #79 On 12/10/2024 at 11:40 AM, during an observation and interview with Resident #79, he was in his wheelchair in the hallway, a urinary catheter drainage bag was visible hanging from the side of the wheelchair and was not covered, leaving the urine visible. He went into his room and stated he was unsure how long he had a catheter or the reason for it. He stated, They usually keep it in a bag when I am out of my room, and noted that it should be in a privacy bag. On 12/10/2024 at 11:45 AM, during an interview, LPN #4 stated the catheter drainage bag should always be in a privacy bag. She explained that the purpose of privacy is to ensure the urine is not openly visible. On 12/11/2024 at 11:40 AM, during an interview, the Director of Nursing (DON) confirmed that urine drainage bags should be kept in a privacy bag so that other residents and visitors are not able to see the resident's urine. A record review of the Admission Record revealed the facility admitted Resident #79 8/1/24 and he had a current diagnosis of Neuromuscular Dysfunction of the Bladder. A record review of the Order Summary Report, revealed Resident #79 had an order, dated 12/3/24, for an suprapubic catheter. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/07/2024 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. 41680

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50751 Based on observation, interviews, record review, and policy review, the facility failed to ensure medications were secured when a medication cart and treatment cart were left unlocked and unattended and failed to ensure medications were not left at a resident's bedside for two (2) of three (3) days of the survey. Findings included: A review of the facility's policy, Medication Labeling and Storage, revised February 2023, revealed, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys .Medication Storage .4. Compartments (including .carts .)containing medications and biologicals are locked when not in use, and .carts used to transport such items are not left unattended if open or otherwise potentially available to others . A review of the facility's Medication Administration - General Guidelines, dated 08/25/2014, revealed, . Procedure .2. Administration .d. Medications are administered at the time they are prepared . Medication Cart: On 12/10/2024 at 11:37 AM, during an observation of the North Unit, a medication cart was noted to be unlocked and unattended in the hallway at the nurse's station until 11:41 AM. During this time, ten (10) residents were observed walking past the cart, but none attempted to open it. On 12/10/2024 at 11:43 AM, during an interview and observation of the medication cart, Licensed Practical Nurse (LPN) #1 confirmed that the cart was unlocked and stated, It was an accident. I got distracted while giving medications. She noted that residents on the hall were ambulatory but stated she had not witnessed any rummaging behaviors, or anyone attempting to go through the medication cart. She acknowledged that a lot could happen if residents were to get into the medication cart, including taking other residents' medications. There were numerous medications for different residents observed on the cart, including liquid valproic acid for seizures and over-the-counter medications such as Tylenol, vitamins, and aspirin. On 12/10/2024 at 2:14 PM, during an interview with the Director of Nursing (DON), she revealed her expectation was that nurses should lock their carts when stepping away. She stated that not locking the cart could result in residents ingesting medications not intended for them. Treatment Cart: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/2024 at 1:49 PM, during an observation and interview, the treatment cart in the hallway located near room [ROOM NUMBER] was noted to be unlocked while the wound care nurse was in the resident's room performing wound care. LPN #2 walked through the hall and locked the cart. She verified the cart had been left unlocked and confirmed there were things on the cart that could be poisonous to residents if ingested. On 12/11/2024 at 1:53 PM, during an observation, Registered Nurse (RN) #1 (Wound Care Nurse) retrieved supplies from the cart, including two (2) Kerlix wraps, but did not lock the cart before returning to the resident's room. At 1:55 PM, RN #1 exited the room, locked the cart, turned it toward the wall, and returned to complete wound care. On 12/11/2024 at 2:00 PM, during an interview with RN #1, she verified the cart had been left unlocked and unattended. The cart contained scissors, antimicrobial solutions, Dakin's solution (diluted bleach), and multiple ointments. The wound care nurse confirmed residents should not have access to these items. Medications at bedside: On 12/11/2024 at 8:08 AM, during an observation, Resident #71 was finishing breakfast. A clear medication dispensing cup with multiple tablets and capsules was observed sitting on the bedside table. The resident stated that the facility staff sometimes left his medications on the bedside table for him to take. On 12/11/2024 at 8:10 AM, during an interview, LPN #5 confirmed that she left medications the residents morning medications unattended at the bedside. She stated she was not supposed to leave medications at the bedside and acknowledged she would not know if the resident had taken the medication or not. On 12/11/2024 at 8:13 AM, during an observation and interview with Resident #71 and LPN #5, the medication dispensing cup was observed to be empty. Resident #71 stated he had already taken the medications. On 12/11/2024 at 8:22 AM, during an interview, the DON confirmed that it was not proper procedure for medications to be left unattended at the bedside. She explained that the nurse would not know if the resident took the medication and emphasized that medications should never be left at the bedside. A record review of the Admission Record revealed the facility admitted Resident #71 on 10/12/2023 with diagnoses including Cerebral Infarction. A record review of Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/2024 revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated he was cognitively intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record view of the electronic Medication Administration Record (MAR) for December 2024, revealed Resident #71's morning medications administered on 12/11/2024 consisted of: Allopurinol 100 milligrams (mg), Amlodipine 10 mg, Ascorbic Acid 500 mg, Aspirin 81 mg, Flomax 0.4 mg, Hydrochlorothiazide 25 mg, Multivitamin, Plavix 75 mg, Amantadine 100 mg, Baclofen 10 mg, Coreg 6.25 mg, Docusate Sodium 100 mg, Metformin 500 mg, Methenamine Hippurate 1 gram (gm), and Gabapentin 400 mg. 41680