STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255210	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Guest Home Inc	133 Pine Street Hazlehurst, MS 39083

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 37415 Based on observation, interviews, record review, and policy review, the facility failed to resolve resident council members' complaints regarding the lack of hot water in a timely manner for one (1) of two (2) halls. Findings included: A review of the facility's policy titled, Conflict Resolution and Resident Complaint and Grievance Process, dated 09/06/2022, revealed, It is this facility's commitment to safe, respectful, and high-quality care, all concerns brought to the organization's attention by residents/legal representatives shall be reviewed in a timely manner. This organization shall respond to such concerns in a timely, reasonable, and consistent manner. Concerns regarding care received shall include, but not be limited to, concerns over perceptions related to premature discharge . All grievances shall receive immediate priority and must be investigated with efforts made toward resolution within 24 hours. If a grievance cannot be resolved within 24 hours, the grievance shall be referred as described below. This organization shall make every attempt to provide a response within seven (7) days of receiving a grievance . If a grievance is not resolved, the investigation is not complete, or if the corrective action is still being evaluated within the seven (7) day timeframe, the facility shall send a response to the resident stating that the facility continues to work to resolve the complaint and the facility shall follow-up with another response within 24 hours . A review of the facility's policy titled, Residents' Rights, dated 2020, revealed, The residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . The resident has the right to a safe, clean, comfortable, and homelike environment, including receiving treatment and supports for daily living safely . Grievances: The resident has the right to: a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal . b. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. A record review of the Resident Council's Comments/Concerns/Suggestions, dated 10/29/2024, revealed residents complained that the hot water took too long to get hot, sometimes running for more than 30 minutes and only getting a little warm. Documentation on 11/26/2024 indicated the complaint was resolved. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/2024 at 10:50 AM, during an initial tour of the facility, Resident #21 requested that the hot water in her bathtub be turned on so the water in her sink would warm. The resident stated she had been complaining about the water not getting hot for the last three months. She explained she was wheelchair-bound, unable to transfer without assistance, and could not turn on the bathtub water herself. She reported having to wash her hands, face, and body in cold water. On 12/11/2024 at 9:00 AM, during an interview, Certified Nursing Assistant (CNA) #1 confirmed she had to retrieve hot water from the soiled utility room to provide incontinent care for residents on the west wing. She reported that staff had informed maintenance about the issue several times with no resolution. CNA #1 stated residents had to wash their hands and face in cold water and confirmed she had to turn on the bathtub water before the sink water would get warm. On 12/11/2024 at 10:00 AM, during a meeting with the resident council members, residents explained all concerns had been resolved except for the issue with the hot water taking a long time to get warm. Resident #21 stated staff had to turn on the bathtub water in her bathroom before the sink water would warm, which she could not do herself. She reiterated having to wash her hands, face, and body in cold water. On 12/11/2024 at 11:30 AM, during an interview, the Activity Director confirmed residents on the west wing had complained about the water not getting hot. She explained she documented the issue as resolved because Resident #21 did not attend the November Resident Council Meeting, and no other residents brought up the concern. She acknowledged she did not confirm with residents that the issue had been resolved. On 12/12/2024 at 9:00 AM, during an observation with Licensed Practical Nurse (LPN) #1, the hot water in Resident #21's room ran for 15 minutes without getting warm. LPN #1 explained that staff had to retrieve hot water from the soiled utility room to assist residents with warm bed baths. She confirmed the water in the residents' rooms barely got warm, even when it eventually warmed. On 12/12/2024 at 10:30 AM, during an observation of water temperature checks and interview, the Maintenance Director confirmed he was aware the hot water was not getting hot on the west wing. He stated he notified a plumbing company on 12/05/2024, which identified a sticking water pump outside the hot water heater. He reported that the facility had ongoing issues with hot water for two to three months and admitted he had not yet called the plumber for further repair. The Maintenance Director stated he turned up the water temperature in an attempt to fix the problem and would turn on Resident #21's bathtub water each morning to ensure warm water for her. The Maintenance Director verified the water temperature in the sink at 80 degrees Fahrenheit. On 12/12/2024 at 11:00 AM, during an interview, the Director of Nursing (DON) confirmed she was aware of the hot water issue and assumed the Maintenance Director had resolved the problem. On 12/12/2024 at 12:15 PM, during an interview, the Administrator confirmed she was aware of the complaint about the hot water not getting hot on the west wing. She stated she believed the Maintenance Director resolved the issue by increasing the water temperature. She was unaware that residents had to turn on the bathtub water to get hot water in the sink and stated she would contact the plumber immediately.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48181 Based on observation, interviews and record review the facility failed to maintain a safe and clean environment related to a leaking roof, damaged ceiling tiles, and thick, black, wet biological growth in air vents for two (2) of three (3) days of observation Findings included: On 12/10/2024 at 10:30 AM, during an observation and interview, Resident #35's room was observed to have a leaking roof near the entranceway, with a blanket draped on the floor. Resident #35 reported that the ceiling was leaking from the light fixture in the entranceway to his room but stated the leaks were not near his bed or where he sits to watch TV. On 12/10/2024 at 10:37 AM, during a facility-wide observation, leaks were observed at various spots throughout the ceiling. Black biological growth was visible in the air vents throughout the facility. On 12/11/2024 at 11:42 AM, during an interview with the Maintenance Director, he acknowledged that the roof was actively leaking throughout the facility and reported that the roof had been leaking for about a year. The Maintenance Director stated his department had been patching areas here and there and confirmed the presence of black biological growth in the air vents, which he attributed to moisture in the ceiling. He reported plans to clean the air vents to remove the biological growth and stated that the Chief Operating Officer (COO) had planned for a new roof for the facility. On 12/11/2024 at 12:00 PM, during an interview, the Administrator acknowledged that the facility had active leaks throughout the building and confirmed the visible presence of black biological growth in the air vents. She stated that the COO had arranged for a roofing company to install a new roof on the building. The Administrator explained that she planned to consult with the roofers before cleaning the air vents because the moisture would persist until the roof was repaired. On 12/11/2024 at 12:14 PM, during an interview, the COO acknowledged that the roof had been leaking for about a year. He reported that the facility had applied for state grant funding to repair the roof but was denied. He stated this was the reason for the delay in roof repairs. The COO confirmed that the facility would now fund the repairs independently and reported speaking with a local roofing company in a nearby town to replace the roof but noted that a date for the roof replacement had not been determined. On 12/12/2024 at 10:12 AM, during a follow-up interview, the Maintenance Director reported that a roofing company was at the facility to patch and caulk areas above Resident #35's room. He confirmed that the company arranged by the COO would still replace the roof but was unable to provide a confirmed date for the replacement. A record review of Resident #35's Admission Record revealed the facility admitted the resident on 01/11/2021. The resident's diagnoses included Unspecified Dementia and Chronic Obstructive Pulmonary Disease (COPD). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #35's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/13/2024, revealed a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.