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 _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILLS COM LIV CENTER	1600 RAYMOND RD JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #23596), at the facility on 12/12/23. The SA investigated the Facility Reported Incident (FRI) related to a violation of resident rights. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and cited F550, as Past Non-compliance (PNC). Based on the facility's implementation of corrective actions on 12/9/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC), and the deficiency was corrected as of 12/10/23, before the SA's entrance on 12/12/23. The facility was licensed for 100 beds and had a census of 82 at the time of survey.	F 000	Past noncompliance: no plan of correction required.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

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

Electronically Signed | 12/27/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility investigation, and facility policy review, the facility failed to treat a resident with respect and dignity during care for one (1) of four (4) residents reviewed. Resident #1 Findings include: A review of the facility's policy, "Resident Rights," dated November 23, 2016, revealed, " ...This facility will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness, and dignity ..."	F 550	Past noncompliance: no plan of correction required.	

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F 550	Continued From page 2	F 550		

A review of the facility's policy "Vulnerable Adults' Prevention Policy," undated, revealed, " ...A Vulnerable Adult is a person 18 years or older who is unable to protect his own rights, interests, and/or vital concerns and who cannot seek help without assistance because of physical, mental, or emotional impairment ..."

Record review of the facility's investigation dated December 12, 2023, revealed at approximately 11:40 AM on 12/9/23, the facility Administrator was notified by the Director of Nursing that Certified Nursing Assistant (CNA) #1 was overheard by Resident #3's visitor and Resident #1's son that CNA #1 was overheard speaking to Resident #1 in an "abrasive tone and language." CNA #1 was heard telling Resident #1 "I don't care."

During a phone conversation on 12/12/23, at 11:48 AM with the son of Resident #1, he revealed as he was walking into Resident #1's room, he overheard a staff member speaking to his father in a loud and rough voice, telling him to "stop pushing back his leg".

On 12/12/23 at 2:30 PM, in an interview with the Administrator, she stated that CNA #1 had admitted that while performing care, she had told Resident #1 that she didn't care. The Administrator confirmed that CNA #1 was disrespectful to the resident, however, was not threatening. She confirmed the facility provided in-services regarding resident rights and abuse/neglect following the incident. The Administrator stated they had an emergency Quality Assurance Performance Improvement (QAPI) meeting to discuss the event and what measures would be implemented.

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F 550	Continued From page 3	F 550		

On 12/12/23 at 2:45 PM, during an interview with the Director of Nurses (DON), she confirmed that CNA #1 was heard being disrespectful to Resident #1 by his son and a visitor. The DON stated it is not the policy of the facility to treat anyone in a disrespectful nature.

Record review of a handwritten statement, dated 12/9/23 and signed by CNA #1 revealed, "I went in to (Room # of Resident #1) to get him changed. I asked him to roll, he started fussing at me saying he don't care ...he just keep on with the fussing and keep saying he don't care so I said 'I don't care'."

On 12/12/23 at 4:15 PM, in an interview with CNA #1, she confirmed that while providing care for Resident #1, he told her he didn't care, and she responded by telling him she didn't care.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/7/23, with diagnoses that included Cerebral Infarction and Hemiplegia, affecting his right dominant side.

Record review of the "BIMS (Brief Interview for Mental Status) MDS (Minimum Data Set) 3.0" dated 12/8/23 revealed Resident #1's BIMS summary score was 9, indicating Resident #1 had moderate cognitive impairment.

Record review of the personnel file for CNA #1 revealed she had received training on the Vulnerable Adults Act and Resident's Rights and signed an acknowledgment on 5/15/23.

Based on the facility's implementation of

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F 550	Continued From page 4	F 550		

corrective actions on 12/9/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC), and the deficiency was corrected as of 12/10/23, before the SA's entrance on 12/12/23.

Validation:

On 12/12/23, the SA validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when the incident occurred.

A review of the emergency QAPI meeting minutes revealed the facility held a QAPI meeting on 12/9/23 at 1:30 PM. The SA verified through an interview with the DON that the facility policies related to resident rights were reviewed and no changes were needed. The QAPI meeting concluded that the Plan of Correction was to in-service all staff, suspend the employee, and interview all residents with Brief Interview of Mental Status (BIMS) over 12 to determine if any other residents experienced any violation of their resident rights.

The SA reviewed in-service sign-in sheets that began on 12/9/23, related to resident rights and abuse/neglect. The Administrator and DON conducted in-services in which they had every employee review and sign the policies on resident rights and abuse/neglect.

The SA verified through record review the facility reported resident abuse to the SA and the Attorney General Office (AGO) on 12/9/23.