| 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 _____ | 02/14/2024 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification at the facility survey from 2/11/24 through 2/14/24. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation and cited deficiencies at F550 and F700.<br><br>The facility held a license for 100 beds, with a census of 84. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, 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.<br><br>§483.10(b) Exercise of Rights. | F 550 | | 3/21/24 |

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

Electronically Signed | 03/07/2024

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.

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| F 550 | Continued From page 1<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record review, the facility failed to treat residents with dignity and respect by failing to consistently ensure call lights were answered in a timely manner for three (3) of 31 sampled residents (Residents #1, 32, and 45) and one (1) unsampled resident (Resident #80).<br><br>Findings include:<br><br>Resident #32<br>On 02/11/24 at 12:30 PM, in an interview with Resident #32, he stated it takes staff over two (2) hours to answer call lights, leaving the resident wet and sometimes soiled waiting for assistance.<br><br>Review of the Minimum Data Set (MDS, with Assessment Reference Date (ARD) of 01/16/24, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.<br><br>Resident #1 | F 550 | It was found by the State Agency (SA) that the facility was deficient in practice due to the failure to treat residents with dignity and respect by failing to consistently ensure call lights were answered in a timely manner for residents #1, #32, #45, and #80. On 2/28/2024 the Social Worker (SW) completed resident interviews with residents #1, #32, #45, and #80 to ensure residents are aware of residents rights related to call lights with no psychosocial harm found.<br><br>All residents who reside in the facility have the potential to be affected by the deficient practice and have been identified as so.<br><br>Beginning on 2/28/2024 and ending on 3/1/2024 all staff were in-serviced by the Social Worker on Residents rights related to call lights and answering them in a timely manner. The Social Worker | |

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| F 550 | Continued From page 2<br>On 02/11/24 at 01:01 PM, an interview with Resident #1 revealed there was a problem with call lights being answered timely. The resident stated she had to lay in urine and bowel movement for over an hour and had complained to the Ombudsman about their concerns.<br><br>A record review of the MDS, with ARD 11/20/23, revealed Resident #1 had a BIMS score of 15, which indicated the resident was cognitively intact.<br><br>Resident #45<br>On 02/13/24 at 12:54 PM, in an interview, Resident #45 complained about the staff not answering the call lights timely.<br><br>A record review of Resident #45's MDS with ARD of 01/08/24, revealed a BIMS score of 15, which indicated the resident was cognitively intact.<br><br>Resident #80<br>A record review of the facility's October grievance log revealed an unsampled resident's wife (Resident #80) had filed a grievance in reference to call lights not being answered timely.<br><br>An interview with the Ombudsman on 2/12/24 at 10:00 AM, revealed she had gotten recent complaints regarding staff not answering lights in a timely manner. The Ombudsmen stated she was at the facility last Tuesday, because of the complaints and had spoken with the Assistant Administrator (AA), Social Service Director (SSD) and Activity Director (AD) along with resident council members.<br><br>On 02/14/24 at 06:38 PM, in an interview with the Director of Nurses (DON), she confirmed she | F 550 | completed a call light evaluation and audit to include proper placement of call lights in rooms and resident education on 2/29/2024. On 2/28/2024 the Social Worker provided an in-service to all staff on residents' rights related to call lights and answering them in a timely manner.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met on 2/28/2024 to discuss policy and procedures on Residents Rights related to dignity and respect with no revisions needed. It was determined by the QAPI team that the Social Worker will complete a monthly staff education on resident rights during the mandatory staff meetings; related to residents right to be treated with dignity and respect by being consistent in responding to the residents call lights in a timely manner.Effective 2/29/2024 the Social Worker will conduct a call light evaluation and audit to include proper placement of call lights in rooms and resident education. Beginning 2/29/2024 the Social Worker will perform interviews with three residents per week for six weeks to ensure proper call light and resident right policy and procedures are being followed; the ending date will be 4/11/2024. The Social Worker or Administrator will perform call light response time audits two times weekly for 8 weeks, beginning 2/29/2024 ending 4/25/2024.Beginning 3/1/2024 the Director of Nursing (DON) will provide comprehensive training to staff on the procedures for call light accessibility and response protocols, ensuring all nursing | |

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| F 550 | Continued From page 3<br>was made aware of the complaints about call lights not being answered timely by the activity's coordinator. The DON stated in response to the complaints the staff were in serviced on importance of answering call bell in a timely manner and staff on all shifts were in serviced.<br><br>On 2/14/24 PM at 6:40 PM, in an interview with the AD, she confirmed a grievance was made in October in relation to call lights not being answered timely. She stated she reported the grievance to the Director of Nursing and notified the Administrator. She stated DON provided an in-service with staff as part of their plan to solve the problem.<br><br>On 2/14/24 at 7:13 PM, in an interview with the SSD, she confirmed during resident council in the month of October there was a complaint about the call light not being answered. She stated the DON was notified and staff were in-serviced. She stated she had not had any more complaints on that topic from the residents since that time.<br><br>On 02/14/24 at 07:16 PM, an interview with the Administrator confirmed residents complained in resident council about the staff not answering the call lights. The Administrator stated she had completed an in-service with the staff explaining the importance of answering the call lights and customer service. The Administrator also confirmed after that in-service, she completed one on-one in-services with staff because there was still a problem with answering call lights in a timely manner. She stated the last in-service on the topic of answering call lights in a timely manner was in December of 2023. | F 550 | staff understands their roles and responsibilities. Beginning 3/1/2024 the Interdisciplinary team will review any grievances during stand-up meetings related to call lights and on-going thereafter any findings will be addressed with immediacy by the Social Worker, the DON or the Administrator. The audits will be reviewed and discussed in the monthly QAPI team meeting beginning 3/20/2024 and ending 9/20/2024; any adverse findings will be resolved immediately by the DON or Administrator | |
| F 700 SS=D | Bedrails | F 700 | | 3/21/24 |

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| F 700 | Continued From page 4<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and facility's policy review, the facility failed to obtain an informed consent for the use of bed rails for seven (7) of eighteen residents reviewed for bedrails. (Resident's #1, #14, #24, #31, #45, #81, and #142)<br><br>Findings include:<br><br>A review of the facility's policy titled, "Bed Safety and Bed Rails," reviewed 8/2023, revealed, ..."Bed rails are properly installed and used according to the manufacturer's instructions, | F 700 | It was found by the State Agency (SA) that the facility was deficient in practice due to failure to obtain an informed consent for the use of bed rails for residents #1, #14, #24, #31, #45, #81, and #142. On 2/14/2024 the Regional Nurse Consultant (RNC) completed an audit on bed rail orders, care plans and assessment forms to ensure accuracy for all residents. On 2/15/2024 the Director of Nursing (DON), completed a bed rail assessment on the residents #1, #14, #24, #31, #45, #81, and #142 to include | |

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| F 700 | Continued From page 5<br>specifications and other pertinent safety guidance to ensure proper fit ... Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent ...."<br><br>An observation on 2/11/24 at 1:01 PM, revealed Resident #1 had both quarter length bedrails up on the sides of her bed. Medical record review revealed that there was not a signed informed consent for the use of bedrails.<br><br>An observation on 2/11/24 at 2:24 PM, revealed Resident #81 lying in bed with both bedrails up on the sides of his bed. A medical record review revealed that there was not a signed informed consent for the use of bedrails.<br><br>An observation on 2/11/24 at 2:48 PM, revealed resident #142 had both quarter length bedrails up on the sides of his bed. A medical record review revealed there was not a signed informed consent for the use of bedrails.<br><br>An observation on 2/13/24 at 9:54 AM, revealed Resident #24 had both quarter length bedrails up on the sides of her bed. A medical record review revealed there was not a signed informed consent for the use of bedrails.<br><br>During an interview on 2/13/24 at 10:16 AM, with the Maintenance Director he stated he routinely does bed and bed rail quality checks.<br><br>During an interview on 02/13/24 at 10:25 AM, with the Administrator revealed the facility has a policy in place that we assess each resident upon admission and as needed for bedrail safety, | F 700 | consents, order review and that all care plans were updated. The Minimum Data Set Nurse (MDS) reviewed care plans for residents #1, #14, #24, #31, #45, #81, and #142 on 2/15/2024 for accuracy with no adverse findings.<br><br>All residents who reside in the facility have the potential to be affected by the deficient practice.<br><br>Beginning on 2/15/2024 and ending on 2/19/2024 all nursing staff were in-serviced by the Director of Nursing (DON) on bed rail assessments, consents, following orders, and care plans related to bed rails. Effective 2/15/2024 the DON will in-service all staff on bed rail assessments, orders, evaluations, care plans, and consents. The DON completed a bed rail evaluation and audit to include evaluation findings, consents, and physician orders for all residents on 2/20/2024. The MDS nurse completed an audit on all residents on 2/20/2024 to ensure accuracy of care plans. The Maintenance Supervisor completed a side rail inspection on 2/20/2024.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met on 2/14/2024 to discuss policy and procedures related to bed rail assessments, consents, orders, and care plans with no revisions needed. It was determined by the QAPI team that the Maintenance Supervisor will complete a monthly side rail inspection; the inspection will be reviewed by the QAPI team | |

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| F 700 | Continued From page 6<br>monitoring, and maintenance. The facility does not have a bedrail consent in place at this time.<br><br>An observation on 2/13/24 at 11:14 AM revealed Resident #14 had both quarter length bedrails up on the sides of his bed. A medical record review revealed there was not a signed informed consent for the use of bedrails.<br><br>An observation on 2/13/24 at 12:54 PM revealed Resident #45 had both quarter length bedrails up on the sides of his bed. A medical record review revealed there was not a signed informed consent for the use of bedrails.<br><br>During an interview on 2/14/24 at 9:16 AM, with the Director of Nursing (DON), she stated that the facility does not currently have consent forms for bedrails signed and placed on the resident's chart.<br><br>An observation on 2/14/24 at 4:35 PM, revealed Resident # 31 had both quarter length bedrails up on the sides of her bed. A medical record review revealed that there was not a signed informed consent for the use of bedrails. | F 700 | monthly for review and recommendations, any adverse findings will be addressed immediately and reported to the DON and Administrator, this will be ongoing thereafter. Beginning 2/21/2024 the Interdisciplinary team will review bed rail assessments during daily stand-up meetings for all new admissions and as needed for current residents. Beginning 2/20/2024 a monthly audit will be performed by the DON to ensure accuracy of bed rail assessments, consents, and care plans of residents for the duration of six months ending 8/20/2024. All findings will be reviewed and discussed in the monthly QAPI team meeting beginning 3/20/2024 and ending 9/20/2024 for review and recommendations. | |