

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/21/2024
NAME OF PROVIDER OR SUPPLIER PLEASANT HILLS COM LIV CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 an investigation, CI MS #24471, for a Facility Reported Incident (FRI), from 3/14/24 through 3/15/24 related to an elopement. The SA returned to the facility to extend the survey from 3/20/24 through 3/21/24. The facility failed to provide supervision to prevent Resident #1, a vulnerable resident, from leaving the facility without supervision. Based on the facility's implementation of corrective actions on 3/9/24 the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and F689 was cited as Past Non-Compliance. The facility's failure to provide supervision resulted in Resident #1 kicking open an entrance door and leaving the facility unnoticed. Resident #1 was last observed by staff members in the facility at 1:15 AM on 3/9/24 and was found at 9:09 AM, which was approximately eight (8) hours later by police in a neighboring town approximately 12 miles from the facility. The facility staff were unaware of Resident #1's absence until 3:15 AM, when a staff member entered his room and noted he was not in his bed. The resident was taken to a local hospital where he was admitted for Acute Kidney Injury and Rhabdomyolysis. During the investigation of the FRI, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/9/24 and existed at: 42 CRF(S): 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and	F 000	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/11/2024

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 000	Continued From page 1 Severity "J." This situation placed Resident #1 and other vulnerable residents at risk for the likelihood of serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/15/24 at 12:40 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 3/9/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 3/10/24, prior to the SA's entrance on 3/14/24. At the time of survey, the facility was licensed for 100 beds and had a census of 86 residents.	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility policy review, and facility investigation review, the facility failed to provide adequate supervision to prevent Resident #1, who was a vulnerable resident, from exiting the facility unnoticed and unsupervised for one (1) of four (4) residents reviewed. Resident #1	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 2 Resident #1 kicked open an entrance door and exited the facility. He was last observed by facility staff to be in his room in bed at 1:15 AM on 3/9/2024. The facility staff were unaware of Resident #1's absence until 3:15 AM when a staff member entered his room and noted he was not in bed. Resident #1 was located in a neighboring town by the police department at 9:09 AM, approximately 12 miles from the facility. Resident #1 had been off the facility grounds and unsupervised for approximately six (6) to eight (8) hours. The facility's failure to provide supervision and ensure the entrance door was secure, put Resident #1 and all other vulnerable residents at risk for the likelihood of serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 3/9/24. The State Agency (SA) notified the Administrator of the IJ on 3/15/24 at 12:40 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 3/9/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 3/10/24, prior to the SA's entrance on 3/14/24. Findings include: Record review of the facility policy, "Emergency Procedure - Missing Resident", undated, revealed, "...Resident elopement resulting in a missing resident is considered a facility	F 689			

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F 689	Continued From page 3 emergency ..." Record review of the facility investigation, dated 3/09/24, revealed Certified Nurse Aide (CNA) #1 identified Resident #1 was not in his room at approximately 3:15 AM on 3/09/24. CNA #1 reported to Licensed Practical Nurse (LPN) #1 and after searching the building and perimeter it was determined that the resident had left the facility without notifying staff. Missing resident procedures were initiated. Resident #1 was located at approximately 8:50 AM by Police Officer #2 from a neighboring town, which was 12 miles from the facility. On 3/14/24 at 1:55 PM, an interview with the Director of Nurses (DON) revealed she was notified by LPN #1 that Resident #1 was missing at 4:10 AM on 3/09/24. She reported the resident was located approximately 11 miles from the facility by Police Officer #2 at or around 8:50 AM and taken to the Police Department (PD) in a nearby town. She stated that she and other staff went to the PD at approximately 9:20 AM on 3/09/24, where she immediately assessed the resident, who had no obvious injury. She reported the resident was wearing a clean burgundy T-shirt, blue jeans and black tennis shoes when located and was carrying three plastic shopping bags which contained some clothing. She described the weather as cool, mild, and dry. The DON stated Resident #1 reported that he had left the facility by kicking open the "side" door and he was trying to get to a city which was approximately 90 miles from the facility to be with family. On 3/14/24 at 10:54 PM, in a telephone interview with CNA #1, she recalled she and CNA#2	F 689			

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F 689	Continued From page 4 observed Resident #1 in his room at approximately 1:15 AM on 3/09/24 and when she made rounds at approximately 3:15 AM on 3/09/24, she did not see him in the bed. She reported that after quickly checking the surrounding rooms and areas, she advised LPN #1 that she was unable to locate Resident #1. Record review of the Police Department's "Offense/Incident Report", dated 3/9/24, revealed Resident #1 was located by Police Officer #2 at 8:55 PM eleven (11) miles from the facility "sitting outside on the curb near Hwy (highway)" and transported to the officer's police department. The report included a statement by Police Officer #2 that he observed the resident sitting on the curb "with a sign in his hand". The statement revealed the officer ran a local check on the information provided by the resident and discovered that he was listed as a missing person from a neighboring city. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated he was cognitively intact. Section E revealed he was not at risk for wandering or elopement. Record review of the " ...Quarterly Evaluation Bundle", dated 12/14/23, revealed Resident #1 was not a wanderer or elopement risk. Record review of the Weather Underground website (www.weatherunderground.com) temperatures between 3:15 AM and 8:55 AM on 3/09/24 were 59 to 60 degrees Fahrenheit with zero (0) precipitation and winds between 5 and 10	F 689			

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F 689	Continued From page 5 miles per hour. The facility submitted the following list of corrective measures: 1. 3/9/2024 at 3:15 AM the Certified Nursing Assistant (CNA) observed the residents' room and noted he was not present. She immediately notified the Licensed Practical Nurse (LPN) on duty. All staff on the unit began a search for the resident throughout the north unit and then moved to the south unit; at this time, all staff were directed by the LPN to conduct a search of all areas of the building and the perimeter. 2. 3/9/2024 at 4:14 AM, the LPN notified the Administrator in Training (AIT) that the staff searched the building and perimeter and could not locate the resident. The AIT notified the Administrator and Director of Nursing (DON) immediately after speaking with the nurse. The Administrator gave instructions to contact the Maintenance Supervisor and the Police Department. The LPN attempted to contact the resident's next of kin and the number was disconnected. 3. 3/9/2024 at 4:35 AM the Maintenance Supervisor arrived at the facility. He checked all exit doors for proper functioning and noted all doors were secure. He began a search of the perimeter including outside buildings and checked all windows noting all windows were secure. 4. 3/9/2024 at 5:00 AM a complete headcount was conducted by the nursing staff and all other residents were located.	F 689			

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F 689	Continued From page 6 5. 3/9/2024 at 5:00 AM a search team was assembled by the DON-and Maintenance-Supervisor-to search surrounding buildings, including churches, convenience stores, local bus stations and all open businesses. The LPN began making calls to all surrounding police stations. The Administrator contacted all local hospitals. 6. 3/9/2024 at 5:30 AM the Officer assigned to the case arrived at the facility and completed a missing person's report. 7. 3/9/2024 at 8:00 AM the Administrator notified the resident's physician to update the missing resident's status. 8. 3/9/2024 at 9:09 AM the Police Department confirmed with the Administrator that the resident was safe and secure at the Police Station. 9. 3/9/2024 at 9:18 AM the Director of Nursing and Social Service Director went to the Police Station, assessed the resident, found no issues or psychosocial harm then transferred the resident to the emergency room because he refused transport by ambulance. The resident was calm and expressed confidence in his purpose for leaving the facility. He stated he kicked the door, left the facility, walked to the corner of the road, caught a ride with two white ladies that helped him make a sign so he could get to (name of city) to see his family. 10. 3/9/2024 at 10:12 AM the DON arrived at the hospital, gave history of incident and medical information to the Physician along with current medications and morning medications that he had not received at this time. The DON remained	F 689			

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F 689	Continued From page 7 with the resident while the nurse obtained vital signs including a blood glucose level and body audit. No issues were noted with skin assessments, all vital signs were within normal limits and the resident stated he felt fine, but his legs were sore. The Physician ordered labs and stated they would complete medical clearance for admittance. 11. 3/9/2024 at 12 PM a Quality Assurance Performance Improvement (QAPI) committee meeting was held regarding the incident involving Resident # 1. In attendance were the Administrator, the DON, the AIT, the Care Plan Nurse, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), the Business Office Manager, the Maintenance Supervisor, the Wound Care Nurse, Medical-Director, the Regional Nurse Consultant, the Regional Director of Operations, and the Social Services Director (SSD). -QAPI minutes included: 3/9/2024 the QAPI committee reviewed the incident, actions taken, and the policy was reviewed with no recommendations for change. 3/9/2024 all facility staff were 100% in-serviced regarding elopement/missing resident policies and procedures prior to returning to work by the AIT and the DON. 3/9/2024 On hundred percent (100%) of all residents were assessed for elopement risk by the Wound Care Nurse and DON. 3/9/2024 Care Plan Nurse performed a 100% audit of all resident's care plans for those identified as an elopement risk.	F 689			

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F 689	Continued From page 8 3/9/2024 DON completed a 100% audit of all residents that were identified as an elopement risk to include visual monitoring, wander guard bracelets and testing. 3/9/2024 100% audit of the elopement book was performed by the Social Services Director and to ensure that all pictures were current. 3/9/2024 Maintenance Supervisor performed elopement drills on all shifts, this will continue for four (4) weeks and monthly thereafter and brought before the QAPI committee each month for review and recommendations. Any issues will be addressed immediately by the Administrator and DON. 3/9/2024 Maintenance Supervisor changed all door codes in the facility. 3/9/2024 AIT ordered keypad covers for all door keypads in the building. 3/9/2024 Maintenance Supervisor placed door alarms on all doors in the facility. The alarms will be monitored daily, and any issues will be addressed immediately by the Administrator and brought before the QAPI committee monthly for review and recommendations. 3/9/2024 Maintenance Supervisor contacted the alarm company to schedule testing of all doors in the building. 3/9/2024 State Department of Health (SA) was notified of the incident. 3/9/2024 the Attorney General's office (AGO) was notified of the incident.	F 689			

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F 689	Continued From page 9 A follow up QAPI meeting was held on 3/11/2024 to discuss the incident; all actions taken were reviewed and determined to be 100% complete on 3/9/2024. The attending staff were the Administrator, the DON, the AIT, the Care Plan Nurse, the Assistant Director of Nursing (ADON)/infection Preventionist (IP), the Business Office Manager, the Maintenance Supervisor, the Wound Care Nurse, the Medical Director, the Regional Nurse Consultant, the Regional Director of Operations, and the Social Services Director. Pleasant Hills Community Living Center alleged that all interventions necessary to remove the immediacy of the incident were accomplished on 3/09/24. On 3/14/24, the SA validated the corrective actions taken by the facility: The SA validated through record review and interview that the staff identified that the resident was not in his room at approximately 3:15 AM and after searching the building and perimeter it was determined that the resident had left the facility without notifying staff. Missing resident procedures were initiated and the resident was located at approximately 8:50 AM in a neighboring community approximately twelve (12) miles from the facility by the local police department. The SA validated through interview that all notifications were made to facility management and the local police regarding Resident #1's elopement. The SA validated through record review and	F 689			

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F 689	Continued From page 10 interview that the facility conducted a headcount of all residents, the Maintenance Supervisor came to the facility and checked all exit doors for proper functioning and ensured all windows were secure. The SA validated through interview that at approximately 5:00 AM a search team was assembled by the DON and Maintenance Supervisor to conduct a search of surrounding buildings to include churches, convenience stores, local bus stations and all open businesses and LPN #1 began making calls to all surrounding police stations; the and all local hospitals, until the time the resident was located. The SA validated through interview and record review Police Officer #1 completed a missing person's report. The SA validated through interview that the Administrator notified the resident's physician of an update on the status of the missing resident. The SA validated through record review and interview that at 9:09 AM the local Police Department confirmed that the resident was safe and secure at the Police Station of a neighboring city, 12 miles away from the facility. The SA validated through interview and record review that at 9:18 AM on 3/09/24, the DON and Social Services Director went to the Police Station and transported Resident #1 to the Emergency Room for evaluation as ordered by the Physician, because the resident had refused to go by ambulance; also that the DON and SSD assessed the resident and found no signs of physical or psychosocial harm. They both	F 689			

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F 689	Continued From page 11 reported that the resident was calm and expressed confidence in his purpose for leaving the facility, and that he stated he kicked the door, left the facility, walked to the corner of the road, and caught a ride with two ladies who helped him make a sign so he could get to a city ninety (90) miles away to see his family. The SA validated through interview that at 10:12 AM, the DON arrived at the hospital with the resident, gave history of incident and medical information to the Physician along with current medications and morning medications that had not been received. The DON remained with the Resident while the nurse obtained vital signs including a blood glucose level and body audit with no issues noted and all vital signs were within normal limits and the Resident stated he felt fine, except his legs were sore. The Physician ordered labs and stated the hospital would complete medical clearance and admit the resident for a psychological evaluation. The SA validated through record review that all staff on duty were interviewed by the DON, AIT and/or Administrator and CNA #1 was the last person to see Resident #1 lying in bed at approximately 1:15 AM while making rounds. The SA validated on 3/15/24 at 9:40 AM through interview and record review and observation of the Business Office Entrance door that the door was locked and secure and LPN #1 indicated she heard the door as staff was going in and out for lunch but never heard a loud noise such as the resident kicking the door. Interview revealed the Maintenance Director checked the door, no damage was noted to the door, and it was functioning properly.	F 689			

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(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 689	Continued From page 12 The SA validated through interview that the Regional Director of Operations and Regional Nurse Consultant conducted a review of the medical record for Resident #1 The SA validated through interview when the resident was located, he was wearing appropriate clothing/footwear, and the outside temperature was 56 degrees. The SA validated through record review and interview that the facility held a QAPI meeting at 12:00 PM on 3/9/24, and those in attendance included the Administrator, AIT, DON, Care Plan Nurse, ADON/Infection Preventionist (IP), Business Office Manager, Maintenance Supervisor, Social Service Director, Wound Care Nurse, Regional Director of Operations, Regional Nurse Consultant and Medical Director. The committee reviewed the Elopement Incident, actions taken, and policy reviewed with no recommendations by the committee to change the policy. The SA validated through record review and interview the facility staff were in-serviced by the AIT and DON regarding elopement/missing resident policies and procedures prior to returning to work. The SA validated through interview with the DON and record review that all residents were reassessed for elopement risk by the DON. The SA validated through interview and record review that the Care Plan Nurse audited all resident care plans for those identified as elopement risk. The SA validated through interview and record	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 13 review the DON audited records of all residents identified as elopement risk for visual monitoring, wander guard bracelets and testing. The SA validated through observation, record review, and interview there were Elopement Books at each nurse's station and the SSD audited the elopement books and ensured all residents identified had current pictures. The SA validated through record review and interview that elopement drills were conducted on all shifts on 3/09/24 and 3/11/24, with drills scheduled weekly for 4 weeks and monthly thereafter. The SA validated through interview that door codes were changed for all doors. The SA validated through interview the alarm company was consulted for additional options for door alarms. The SA validated through record review and interview that keypad covers were ordered for all exit doors. The SA validated through record review and interview that the Administrator notified the SA of the incident. The SA validated through record review and interview that the Administrator notified the Attorney General's Office of the incident. The SA validated through interview that the SSD located the Resident's family and notified them of the resident's elopement and hospitalization.	F 689			

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F 689	Continued From page 14 The SA validated through record review that the facility held a QAPI Committee meeting on 3/11/2024 and discussed the outcome of the incident and that the QAPI Committee determined that before the incident, Resident #1 was not identified as a risk for elopement, was properly dressed, packed some belongings and was trying to get to see their family. The SA validated the Social Service Director spoke to the family and was working closely with Resident #1 to initiate discharge planning at the request of Resident #1.	F 689			