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 _____	R 04/08/2024

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

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{F 000}	INITIAL COMMENTS On 4/8/24, the State Survey Agency (SA) conducted a Revisit Survey and a Complaint Survey (CI MS #24695). The revisit survey determined the facility had implemented corrective measure for F700 and this deficiency was determined be in compliance as of 3/21/24. During the complaint survey, the SA determined the facility remained out of compliance with regulation F550 related to resident respect and dignity; therefore, the facility remains out of substantial compliance with the Medicare and Medicaid Requirements for participation. The facility held a license for 100 beds, with a census of 83.	{F 000}		
{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, severity of condition, or payment source. A facility must establish and maintain identical policies and	{F 550}		4/23/24

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

Electronically Signed | 04/23/2024

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 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 facility policy review, record review and interviews the facility failed to ensure that residents were treated and spoken to in a dignified and respectful manner for two (2) of four (4) sampled residents. Resident #1 and Resident #2. Findings include: Review of facility policy titled, "Behavior of Employees," revised 12/13/17, revealed, " Policy It is the policy of the Company that certain rules and regulations regarding employee behavior are necessary ... Appropriate employee conduct includes: a. Treating all residents, visitors, and coworkers in a courteous manner; b. Refraining from behavior or conduct that is offensive ..."	{F 550}	Resident #1 and Resident #2 were interviewed by the Social Worker on April 5, 2024, and there were no negative outcomes. A resident council meeting was held by the Administrator on April 16, 2024, to ensure that all residents were informed of their resident rights and right to a dignified existence within the facility. All residents that reside in the facility have the potential to be affected. The Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Assistant Administrator direct in-serviced all employees on resident rights related to respect and dignity and	

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{F 550}	Continued From page 2 Record review of facility document titled, "Resident Rights," revised and implemented on 11/28/16, revealed, "(a) Residents Rights. The resident has a right to a dignified existence ... (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 ..." On 4/04/24 at 9:03 AM, during a telephone interview with the facility Ombudsman, she confirmed that she visited the facility at least monthly and visited with residents. The Ombudsman revealed that she had received complaints from residents related to the way Licensed Practical Nurse (LPN) #1 had treated at spoken to them. The Ombudsman stated that residents had reported to her that LPN #1 routinely spoke to them in a loud, rude, and aggressive manner. On 4/04/24 at 11:00 AM, an interview with a Resident, who requested to remain anonymous, revealed LPN #1 was "rude" and had spoken to her disrespectfully. The resident stated that she had also witnessed LPN #1 speak disrespectfully to other residents. The resident explained that she had witnessed LPN #1 yell at residents to "go to bed, go back to your room." The resident stated LPN #1 told the residents what she was going to do and not going to do. She said that she had also witnessed LPN #1 "fuss" at residents and tell them that she was not going to come back to answer their call light again, so they better tell her everything they wanted or leave the call light alone.	{F 550}	behavior of employees for all staff on 4/4/2024, and they were completed on 4/8/2024. Resident interviews were conducted by the Social Worker with all residents who are cognitively intact beginning April 4, 2024, and ending April 5, 2024, to ensure that all grievances related to resident rights or behavior had been addressed. A Quality Assurance Performance Improvement (QAPI) meeting was held on 4/04/2024 to discuss the policy and procedure of resident rights and behavior of employees, with no changes deemed necessary. It was determined by the QAPI team that the Administrator, the DON or the ADON will perform a questionnaire through both staff and resident interviews on resident rights and behavior of employees with two (2) staff members and four (4) residents weekly for four (4) weeks and then monthly for 6 months thereafter beginning 4/08/24 and ending 10/09/2024. Any identified concerns will be addressed immediately reported to the Administrator and brought to the monthly QAPI meeting effective 4/8/2024 and then monthly for 6 months thereafter ending 10/09/2024.	

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On 4/04/24 at 11:55 AM, during an interview Resident #2 reported that LPN #1, that was rude and disrespectful to her and that she had witnessed LPN #1 being disrespectful to other residents. Resident #2 stated, "LPN #1 is always hollering at residents." Resident #2 reported that she had witnessed LPN #1 yelling at residents to "go to bed." She stated LPN #1 would tell residents to "Get in your room. Go to sleep." The resident described LPN #1 as "loud and aggressive."

On 4/04/24 at 12:10 AM, an interview with a family member of Resident #2, she reported that she visited the facility frequently during different shifts and had witnessed LPN #1 yelling at residents. The family member stated that she felt it was more than speaking loudly to be heard because LPN #1 was yelling orders at the residents. She provided examples of things she had heard LPN #1 yelling at residents, "like telling them to get in their rooms and go to bed." she added, "some of these residents didn't even seem to be able to understand."

On 4/04/24 at 1:50 PM, in an interview with Resident # 1, the previous Resident Council President, she revealed that the behavior of LPN #1 had been discussed in the Resident Council meetings. The resident stated the Activity Director had taken notes for the meetings, but she was not sure if concerns related to LPN #1 were recorded or not. The resident complained that LPN #1 was rude and disrespectful to residents, especially if she was assigned to their care and they requested anything. Resident #1 commented that it was reported that during a recent incident, when a resident requested something for their cold/allergy symptoms, LPN #1 told the resident

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"No, you can't have that and walked out."

On 4/04/24 at 5:00 PM, an interview with the Social Services Director (SSD) revealed that any staff member could document a grievance and that the grievances were turned in to her, and she directed them to the appropriate department head to be addressed. The SSD confirmed that she had received a grievance today from the Staffing Coordinator about a report she had received regarding the loud, rude, and aggressive behavior of LPN #1.

On 4/05/24 at 1:58 PM, during an interview with the Staffing Coordinator, she confirmed Certified Nursing Assistant (CNA) #1 reported to her that LPN #1 "needed to learn how to talk to people." CNA #1 had stated that LPN #1 was loud and that there had been complaints from residents that they did not like LPN #1's tone or volume and felt she was not speaking to them in a respectful manner.

On 4/05/24 at 2:10 PM, an interview with the Assistant Director of Nurse (ADON), revealed the facility provided routine in-service training related to Resident Rights and treating residents with respect. She stated that the facility also provided routine in-service training related to Resident Abuse and Neglect Prevention and Reporting. The ADON commented that she had not witnessed or heard any allegations involving LPN #1 which rose to the level of verbal abuse, but had received a report of an allegation that LPN #1 had spoken to a resident in a rude, disrespectful manner and the allegation was currently being investigated and could result in the termination of the employment of LPN #1 from the facility because LPN #1 had already received multiple

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coaching and verbal warnings regarding therapeutic communication.

Record review of the Record of Corrective Coaching and Witness Statement dated 3/13/24 and signed by the Director of Nurses (DON) revealed that on 3/13/24, LPN #1 received a verbal warning regarding behaviors and attitude and received an additional "in-service on conduct of behavior for employee and therapeutic communication."

Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 9/10/13, with diagnoses that included End stage renal disease and Type 2 diabetes.

Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/12/24, for Resident #1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 8/16/22, with diagnoses that included Chronic respiratory failure and Neuralgia.

Record review of the 5-Day MDS, with ARD 3/08/24, for Resident #2, revealed the resident had a BIMS score of 12, which indicated no cognitive impairment.