

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

PRINTED: 08/05/2024
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 07/11/2024	
NAME OF PROVIDER OR SUPPLIER PLEASANT HILLS COM LIV CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1600 RAYMOND RD JACKSON, MS 39204			
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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and six (6) Complaint Investigations (CI MS #25528, CI MS #25529, CI MS #25530, CI MS #25348, CI MS #25737, and CI MS #25777), at the facility from 7/8/24 through 7/11/24. The SA investigated CI MS #25528 and CI MS #25529 related to nursing services, CI MS # 25530 related to misappropriation of Property, CI MS #25348 related to facility staffing and resident rights, CI MS #25737 related to an allegation of a resident elopement, and CI MS #25777 related to an allegation of resident left wet and neglect. There were no citations related to the CIs. During the recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F657, F689, F690, and F693.			F 000			
F 657 SS=D	The facility was licensed for 100 beds and had a census of 83 at the time of survey. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of			F 657			8/6/24

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

TITLE

(X6) DATE

Electronically Signed

08/01/2024

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 657	Continued From page 1 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to revise a comprehensive care plan intervention when an order changed related to accuchecks for one (1) of 20 sampled residents. (Resident #62) Findings include: Review of the facility's policy, "Care Plans, Comprehensive Person-Centered", reviewed 10/2022, revealed, "...A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...Policy Interpretation and Implementation...11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." Record review of the comprehensive care plan with an intervention target date of 08/18/2024 revealed "Focus I have a DX (Diagnosis) of	F 657	A record review of the comprehensive care plans for Resident #62 were reviewed and updated on 7/12/2024 by the Minimum Data Set Nurse (MDS) to reflect current orders were updated and addressed. The deficient practice of failing to revise a comprehensive care plan intervention when an order changed has to potential to affect all resident who reside in the facility. On 7/12/2024 The Director of Nursing directly in-serviced the Minimum Data Set Nurse and The Medical Records Nurse on Care Plan timing and Revision. On 7/11/2024 the Medical Records Nurse (MR) and the Regional Nurse Consultant completed a 100% audit on all resident's orders with no adverse findings. On 7/15/2024 the Director of Nursing directly in serviced the Minimum Data Set Nurse and the Medical Records Nurse on care plan revision and timing.		

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F 657	Continued From page 2 Diabetes Mellitus...Intervention ...HumaLOG KwikPen Subcutaneous Solution ... sliding scale ..." This was a Physician's Order that had been discontinued. There was no intervention for the current physician's order related to accuchecks weekly. Record review of the "Order Summary Report", with active orders as of 7/11/24, revealed Resident #62 had a current physician's order, dated 6/16/24, "Accuchecks weekly one time a day every Sun (Sunday)...BSG (Blood Sugar Glucose)..." Record review of the discontinued physician's orders revealed Resident #62 had a Physician Order for HumaLog KwikPen with sliding scale (ss) coverage that was discontinued on 6/12/24. On 7/11/24 at 8:49 AM, in an interview with Licensed Practical Nurse (LPN) # 2/Minimum Data Set (MDS) nurse, she stated the care plan nurse was responsible for revising care plans and the care plan nurse was currently on vacation. She explained the care plan nurse ran a report daily of all new orders written for the previous 24 hours and updated/revised the care plan according to those orders. She confirmed the care plan had not been revised when the physician's order changed from accuchecks with ss coverage to accuchecks weekly without ss coverage. On 7/11/24 at 9:51 AM, in an interview with the Director of Nursing (DON), she stated she expected the care plans to be revised when physician orders change because conflicting interventions could cause confusion when caring for the residents.	F 657	The Quality Assurance Performance Improvement Team (QAPI) met on 7/12/2024 and discussed policy and procedures related to care plan timing and revisions with no revisions needed. Effective 7/15/2024 the Medical Records Nurse will review all new orders during the daily stand-up meeting to ensure the accuracy of plans are updated, and ongoing thereafter. Effective 7/15/2024 the Minimum Data Set Nurse will review each new order received on the 24-hour report with the Medical Records Nurse during daily clinical stand-up meetings to ensure accuracy on the revision of care plans continuing indefinitely. Any adverse findings will be addressed immediately during the clinical daily stand-up meetings and then discussed in the monthly Quality Assurance Performance Improvement Meetings for review and recommendations. Any identified concerns will be addressed immediately and reported to the Administrator and brought to the monthly QAPI meeting beginning 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.		

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F 657	Continued From page 3	F 657			
F 689 SS=D	Record review of the "Admission Record" revealed the facility admitted Resident #62 on 4/27/23 with current diagnoses including Type 2 Diabetes Mellitus. 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, and facility policy review, the facility failed to conduct a safety smoking assessment for a resident to safeguard against the potential hazards for burns and/or fires. This concern was identified for one (1) of three (3) residents reviewed for accidents and hazards. Resident #1 Findings include: Review of the facility's policy, "Smoking", undated, revealed, " ...It is the policy of this facility to provide a safe environment for residents who smoke ...Additional precautions may apply to some residents due to safety awareness concerns or medical conditions ...Procedure for Resident safety during smoking 1) Residents with known history of smoking ...will be evaluated on admission, quarterly, and as needed for safety awareness and any physical limitations related to	F 689	The facility failed to conduct a safety smoking assessment for resident #1 to safeguard against the potential hazards for burns and/or fires. On 7/11/2024 the Director of Nursing (DON) performed a smoking assessment on resident #1 and identified no issues. All residents that smoke have the potential to be affected. On 7/11/2024 the DON completed a 100% audit on all residents who smoke to ensure all smoking assessments were completed and up to date per policy and procedures. All residents are found to be in compliance with the smoking policy. The DON, Assistant Director of Nursing (ADON) and Administrator were directly in-serviced on 7/10/2024 by the Regional	8/6/24	

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F 689	Continued From page 4 smoking safety ..." On 7/9/24 at 9:55 AM, in an interview with Resident # 1, she explained she smoked at the designated times and had always smoked since she was admitted to the facility several years ago. Record review of the medical record revealed a "Smoking and Tobacco Evaluation", dated 7/6/2021. Resident #1 did not have a current smoking safety evaluation completed. A record review of the "Admission Record" revealed the facility initially admitted Resident #1 on 9/10/2013 and she had current diagnoses including End Stage Renal Disease. A record review of the Comprehensive Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/23 revealed Resident #1 currently used tobacco. On 7/11/24 9:21 AM, in an interview with the Licensed Practical Nurse (LPN) #2/MDS nurse, she confirmed Resident #1 had not been assessed for smoking since 2021. She stated Resident #1 had been a resident at the facility for a long time and had always smoked. She explained that smoking assessments are completed for residents quarterly and not assessing residents for safe smoking could put them at risk for burns. LPN #2 explained it was the responsibility of the nursing supervisors to complete the assessment form per the facility's policy. On 7/11/24 at 10:21 AM, in an interview with the Director of Nurses (DON), she confirmed that not having a smoking assessment puts residents at	F 689	Nurse Consultant (RNC) on proper completion of the safety smoking assessments on all residents in the facility. All nursing staff were in-serviced by the DON on 7/10/2024 on proper completion of the safety smoking assessments of all residents which reside in the facility. The Quality Assurance Performance Improvement Team (QAPI) met on 7/12/2024 and discussed policy and procedures related to proper completion of the smoking assessment for all residents with no revisions needed. Effective 7/15/2024 and ongoing indefinitely all quarterly assessments will be reviewed during the daily stand-up meetings by the DON or Administrator, discussed with the Interdisciplinary Team and reviewed in the weekly Persons at Risk meeting to ensure proper compliance with the smoking assessment are followed. Effective 7/15/2024 and ending 12/6/2024 the RN supervisor will sign off on all Quarterly Smoking and Tobacco Evaluations on the sign off sheet for each Nurse station. This sign off sheet will be reviewed by the DON and the MDS nurse daily for accuracy in the daily stand-up meeting. Effective 7/15/2024, the RN Supervisor on duty is assigned by the DON to complete the smoking evaluations due to be reviewed quarterly. The MDS Nurse will verify any assessments due to ensure completion and accuracy and then report it in the daily stand-up meeting. Any identified concerns will be addressed immediately and		

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F 689	Continued From page 5 risk for burns. The DON stated the staff should use information from the smoking assessment to ensure a safe smoking environment for Resident #1. She revealed the smoking evaluation form should be completed by the nursing supervisors and Resident #1's "must have gotten missed."	F 689	reported to the Administrator and brought to the monthly QAPI meeting beginning 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.		
F 690 SS=D	A record review of the Quarterly MDS with an ARD of 5/7/24 revealed Resident #1 had a Brief Interview for Mental Status score of 15, which indicated she was cognitively intact. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		8/6/24	

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F 690	Continued From page 6 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure indwelling catheter tubing was secured to prevent complications for one (1) of one (1) resident reviewed with an indwelling catheter. Resident # 3 Findings include: A review of the facility's policy "Catheter Care, Urinary" dated 8/25/14, revealed, " ...The purpose of this procedure is to prevent catheter-associated urinary tract infections ... 17. Secure catheter utilizing a leg band ..." On 7/11/24 at 8:30 AM, during an interview and observation of catheter care with Certified Nurse Aide (CNA) #1 and Licensed Practical Nurse (LPN) #1 revealed Resident #3 had an indwelling catheter but there was no leg strap to secure the tubing. CNA #1 and LPN #1 confirmed the resident did not have a leg strap in place. LPN #1 stated she would get one for the resident and explained a leg strap was used to secure the catheter tubing to prevent the tubing from pulling or becoming dislodged.	F 690	The facility failed to ensure indwelling catheter leg tubing was secured to prevent complications for one (1) of one (1) resident reviewed with an indwelling catheter. Resident #3 was assessed on 7/11/2024 by the Assistant Director of Nursing (ADON) with no issues identified. The Assistant Director of Nursing ensured Resident #3 had their catheter strap in place and adjusted per Catheter care and Urinary policy with no issues identified. All residents who reside in the facility with an indwelling catheter have the potential to be affected. On 7/12/2024 the Assistant Director of Nursing and the Register Nurse Supervisor completed a 100% audit on all residents with indwelling catheters to ensure that each one had a proper leg strap in place. All residents are found to be in compliance with the Catheter Care and Urinary policy. On 7/12/2024 the Medical Records Nurse audited and updated all task administration check offs for residents with catheter care to include		

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F 690	Continued From page 7 Record review of the "Order Summary Report" with active orders as of 7/12/24 revealed Resident # 3 had a Physician's Order, dated 1/19/24, to "Check urinary catheter leg strap every shift and replace as needed ..." On 7/11/24 at 10:30 AM, during an interview with the Administrator and the Director of Nursing (DON), the DON explained that all residents with an indwelling catheter should have a leg strap to secure the tubing. The Administrator reported that she expected the staff to provide quality care to the residents. A record review of the "Admission Record" revealed the admitted Resident # 3 on 12/28/23 with current diagnoses including Neuromuscular Dysfunction of Bladder. A record review of Section H of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/24, revealed Resident # 3 was coded for an indwelling catheter.	F 690	checking for leg strap intact; with 100% accuracy. On 7/11/2024 the RN Supervisor and all other nursing staff were in-serviced by the DON and ADON on urinary catheter care procedures, to include proper leg strap placement. The Quality Assurance Performance Improvement Team (QAPI) met on 7/12/2024 to discuss policy and procedures related to urinary catheter care and proper placement of leg straps with no revisions needed. Effective 7/13/2024 the Registered Nurse Supervisor will make daily rounds on residents with catheter care needs and complete a daily sign off on the daily task to ensure accuracy of proper leg strap and report to the Assistant Director of Nursing any adverse findings ending 10/7/2024. Effective 10/8/2024 the Registered Nurse Supervisor will make rounds on residents with catheter care needs three times a week to ensure continuity of care and accuracy of proper leg strap and report to the Assistant Director of Nursing any adverse findings ending 12/6/2024. The Assistant Director of Nursing will monitor the daily task charting beginning 7/13/2024 and ending 12/6/2024. Any identified concerns will be addressed immediately and reported to the Administrator and brought to the monthly QAPI meeting beginning 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		8/6/24	

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F 693	Continued From page 8 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to label and date enteral feeding bags for three (3) of four (4) observations for a resident with enteral feedings. Resident # 24 Findings include: Review of the facility's policy "Enteral Feeding Via Continuous Pump", dated 8/25/2014, revealed, "The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally ...Steps in the Procedure ...Initiate Feeding ...5. On the formula	F 693	The facility failed to properly label and date enteral feeding bags for resident #24. Resident #24 was assessed by the Assistant Director of Nursing (ADON) on 7/11/2024 with no issues identified. The ADON verified the orders for enteral feeding for resident #24 for accuracy then dated the enteral feeding bag with correct date on 7/11/2024. This deficient practice of not properly labeling and dating enteral feeding bags can affect all residents within the facility who rely on feeding bags for enteral		

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F 693	Continued From page 9 label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order ..." During an observation on 7/8/24 at 11:42 AM, Resident #24 had a feeding tube bag hanging from a pole in her room. The bag was not labeled to indicate the name of the formula or the date and time of when the bag was hung. During an observation, on 7/9/24 at 8:44 AM, Resident #24's tube feeding bag was not labeled and dated to indicate the time the bag was hung, or the name of the substance in the bag. During an observation, on 7/10/24 at 9:46 AM, Resident # 24's tube feeding bag was not labeled to indicate the type of formula and there was no date to indicate the time the bag was hung. During an interview and observation, on 7/10/24 11:23 AM, with Licensed Practical Nurse (LPN) #1, she confirmed the feeding bag was not labeled with the type of feeding or the date it was hung. She stated she checked the residents' rooms every morning to verify the rate on the feeding pumps were accurate because the previous shift was responsible for changing and labeling the tube feeding bag, the tubing, and the feedings. She explained she did not notice the feeding tube bag was not labeled. During an interview on 7/10/24 at 2:43 PM, with the Director of Nursing (DON), she explained it was the night nurses' responsibility to label the feeding tube bags with the type of feeding, date, time and initial the time the feeding was hung or administered.	F 693	feedings. On 7/11/2024 the ADON completed a 100% audit on all enteral feeding bags to ensure proper compliance with the Enteral Feeding via continuous pump policy with no additional adverse findings or changes needed. The Assistant Director of Nursing was directly in-serviced on 7/11/2024 by the Director of Nursing and the Regional Nurse Consultant on Enteral Feeding via Continuous Pump policy and procedures. All nursing staff were in-serviced by the DON on 7/11/2024 on Enteral Feeding via continuous pump policy and procedures. The Quality Assurance Performance Improvement (QAPI) team met on 7/12/2024 and discussed the policy and procedures related to enteral Feedings via continuous pump for all residents with no revisions needed. Effective 7/15/2024 the Register Nurse Supervisor will complete a shift check off on enteral feeding bags for proper labeling and dating daily for 4 weeks ending 8/12/2024. Effective 8/13/2024 the Registered Nurse Supervisor will complete a shift check off on enteral feeding bags two (2) times a week for four (4) weeks ending 9/9/2024 to ensure proper labeling and dating of enteral feeding bags. Effective 7/15/2024 the ADON will verify the shift check off has been completed daily; this information will be brought to the daily stand-up meetings. Any identified concerns will be addressed immediately and reported to the Administrator and brought to the monthly QAPI meeting effective 8/5/2024		

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

PRINTED: 08/05/2024
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 07/11/2024
NAME OF PROVIDER OR SUPPLIER PLEASANT HILLS COM LIV CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 RAYMOND RD JACKSON, MS 39204		
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F 693	Continued From page 10 A record review of the "Medication Administration Record" for 7/1/24 through 7/31/24 revealed Resident #24 had a Physician's Order, with a start date of 3/12/24, for " ...Isosource 1.5- 40 ml/hr (milliliters per hour) x (times) 22 hrs ..." A record review of the "Clinical" record revealed the facility admitted Resident #24 on 9/20/23. A record review of the of the Quarterly Minimum Data Set (MDS), dated 05/01/2024, revealed Resident # 24 received nutrition via a feeding tube.	F 693	and then monthly for 5 months thereafter ending 12/6/2024.		