MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 000	Initial Comments	M 000		

Initial Comments
AMENDED 8/23/21
The State Agency (SA) conducted Complaint Investigations (CI) MS#00017869, MS#00017884, and MS#00017935 on 7/08/21 through 7/17/21 at the facility. During the survey, the facility was determined not to be in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements a M. The SA substantiated CI MS#00017869 and MS#00017935 related to elopements, when the facility failed to provide adequate staff supervision to prevent Resident #1 and Resident #5's elopements. The SA substantiated CI MS#17884 related to a fall with an injury for Resident #6..

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/1/21, when the facility failed to provide adequate supervision to prevent the elopement of Resident #1, who was gone from the facility unsupervised for approximately 88 minutes and found lying on his back on the asphalt parking lot of the building next door to the facility. Resident #1 had minor abrasions of the left arm and leg, a bruise on the top of the left hand and a skin tear on the left knee. During the survey on 7/14/21, Resident #5 eloped from the facility for approximately 16 minutes and was found approximately 0.6 miles from the facility. On 7/2/21, Resident # 6 sustained a fall resulting in a displaced right femoral neck fracture.

The facility's failure to provide supervision to prevent the elopements of Residents #1 and #5 and failied to prevent a fall with injury for Resident #6 placed these residents and other residents at risk, in a situation that was likely to cause serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 000	Continued From page 1 harm, injury, impairment, or death. On 7/12/21 at 1:15 PM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ Template. An additional IJ Template was provided on 7/14/21, when Resident #5 eloped. The IJ and SQC existed at: Rule 45.21.8, M 640, Accidents - Level IV Rule 45.17.2 - M 500 Resident Rights - Level IV The facility submitted an acceptable Removal Plan on 7/15/21, in which they alleged all corrective actions to remove the IJ were completed on 7/15/21, and the IJ removed on 7/16/21. The SA validated the Removal Plan on 7/17/21, and determined the IJ was removed on 7/16/21, prior to the exit. Therefore, the scope and severity for Rule 45.21.8, M 640, Accidents and Rule 45.17.2 Resident Rights M 500 was lowered to a Level III while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of the survey, the facility had a census of 87 and held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's	M 500		8/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 2 written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment),	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 3 and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 4 possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 5 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from neglect, related to a fall with injury for one (1) of five (5) residents reviewed. Resident #6. Findings include: Review of the facility "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms... Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. ...Neglect- failure of the facility, its employees or service providers to provide goods and services	M 500	1. The Director of Nursing (DON) and Administrator suspended Registered Nurse (RN) # 7 and Certified Nursing Assistant (CNA) # 7 on 7/7/21. The DON and Administrator terminated CNA # 7 and RN # 7 on 7/15/21. The Administrator reported RN # 7 to the MS Board of Nursing on 7/8/21. 2. All residents in the facility have the potential to be affected by this practice. 3. On 7/6/21 The Administrative Team completed an in-service with all staff on abuse, neglect, misappropriation. On 7/8/21 the Administrator, Director of Nursing (DON), Nurse Supervisor, and Business Office Manager (BOM)/ HR completed an in-Service with all nurses regarding incidents/accidents, assessing, documentation, and reporting. On 7/8/21 the Administrator, DON, Nurse Supervisor, and BOM/ HR completed an in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 6 to a resident necessary to avoid physical harm, mental anguish, or emotional distress ... Staff will be supervised to identify inappropriate behaviors such as derogatory language; rough handling; ignoring residents while giving care; directing residents who need toileting assistance to urinate or defecate in their beds ..." Record review of the "Admission Record" revealed Resident #6 was admitted on 8/12/20, with diagnoses that included Dementia, Transient Ischemic Attack (TIA), and Schizoaffective disorder. Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated Resident #6 has severe cognitive impairment. Record review of the facility's "CES Quarterly Evaluation Bundle (Clinical-V11)" dated 5/12/21 revealed "2. Fall Risk Evaluation Instructions: If the score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Resident #6's Fall Risk Score was 21." Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have copious amount of vomit in her bed ...Resident assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..."	M 500	with all staff regarding reporting accidents, reporting abuse, neglect, chain of command, and when to call protocol. 4. The Administrator, Director of Nursing (DON), Minimum Data Set (MDS) Nurses, Social Services Director (SSD), or Business Office Manager (BOM)/HR will perform random audits to ensure residents rights are adhered too and residents are free from abuse, neglect, misappropriation, and exploitation. These audits will be in the form of staff interviews regarding abuse, neglect, misappropriation, and exploitation policy including reporting and investigating. The Administrator, DON, MDS Nurses, SSD, or BOM/HR will complete an audit to begin on 7/19/21 and will interview three (3) staff members weekly for thirty (30) days then three (3) staff members monthly for three (3) months. Any concerns related to abuse, neglect, misappropriation, and exploitation will be addressed immediately. The results of such audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 4 months to end on November 19, 2021. The first QAPI meeting to review such audits will be held in August 2021. If the Quality Assurance Team identifies concerns or non-compliance, the team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 7 Record review of the local hospital progress note dated 7/6/21 revealed " Patient was seen and examined today. Patient is a terrible historian. She constantly yells out with any movement of her right leg. Case was discussed with physical therapy. Imaging obtained." Record Review of the local hospital x-ray report dated 7/6/21 revealed a displaced right femoral neck fracture. Record review of the facility investigation dated 7/6/21, revealed there were no recent falls or incidents documented from the hospital. The investigation at the facility revealed that there was an incident regarding Resident #6 on 7/2/21. RN #7 and CNA #7 reported two different stories. RN #7 changed her story multiple times, did not document, and was reported to the state Board of Nursing by the facility. No other staff members were identified to have witnessed the incident. During an interview on 7/13/2021 at 10:30 AM, with RN #7 revealed she was called to Resident #6's room by CNA #7 on 7/2/2021 at 8:00 AM. RN #7 said Resident #6 was sitting in the wheelchair crooked. RN #7 said CNA # 7 helped her straighten the resident up in the wheelchair. RN # 7 said she suspected Resident # 6 must have fell and put herself in the wheelchair crooked. RN #7 said she did not do an incident report or notify anybody because she wasn't for sure if the resident fell. RN # 7 said Resident #6 has had several falls and complains of pain all the time. RN # 7 said Resident #6 vomited later during the day and complained of pain. RN #7 said she gave Resident #6 Zofran for nausea and a pain pill. Interview on 7/13/21 at 10:45 AM, with CNA #7 revealed on 7/2/21 at 7:00 AM she heard a	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 8	M 500		

resident scream "help.". CNA #7 said she saw Resident #6 on the floor. CNA # 7 said she called for RN#7. RN #7 asked CNA #7 if the resident hit her head. CNA #7 said she thinks she did because her head was against the wall. RN #7 said "I don't have time for this. I am not sending her out because she falls all the time. She's, ok". CNA #7 said she took the resident to the dining room after assisting RN #7 with putting her back in the wheelchair. CNA # 7 said Resident #6 was very confused, would not eat and complained of pain to her arm. CNA # 7 said CNA #8 was in the dining room. CNA #8 asked CNA #7 if Resident #6 was OK. CNA #7 told CNA #8 that Resident #6 fell this morning in her room. CNA #7 also said RN #7 did not write an incident report, nor send the resident to the hospital for an x-ray. CNA #8 told CNA #7 to go back to RN #7 and write a statement to cover herself. CNA #7 said CNA #9 also asked during breakfast, what is wrong with Resident #6. CNA #7 said Resident #6 fell, and RN #7 did not write an incident report or send the resident to the hospital to be evaluated. CNA #9 also told CNA #7 to write a statement and keep it because the Administrator or somebody will come to her to find out what happen. CNA # 7 said Resident #7 continued to complain of pain. CNA #7 went to the nurse and said Resident #6 continues to complain of pain. CNA #7 told RN #7 that Resident #6 probably needs to go to the hospital. RN #7 refused to send her out. CNA # 7 said after lunch the resident vomited and continued to complain of pain to her back. CNA #7 said she cleaned the resident up and let RN #7 know the resident had vomited and complained of pain. RN #7 gave the resident something for pain and nausea. CNA #7 said when she came back to work the next day, she was told Resident #7 was sent to the hospital for vomiting and pain. CNA #7 said RN #7 came to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 9	M 500		

her saying they need to get their story together. CNA #7 said she told the RN #7 that she wrote a statement. CNA #7 said a couple of days later the Administrator called her and ask if Resident #6 had a fall. CNA #7 said "no" Resident #6 did not fall. The Administrator asked her to write a statement and bring it to the facility. CNA # 7 said she came to the facility and talked to the Administrator. CNA #7 said she told the Administrator that she needed to tell the truth because she did not realize the resident had a fractured hip. CNA # 7 said she told the Administrator that she heard Resident # 6 scream "help me." CNA #7 said she found Resident #6 on the floor. CNA #7 said she called RN #7 to the room. CNA #7 also stated that she told the Administrator that RN #7 refused to send the resident out to the hospital because she didn't have time and the resident always falls and complains of pain. CNA # 7 said she felt bad because RN #7 told her the Resident did not receive any broken bones and the Resident was ok. When she realized Resident #6 had a right hip fracture, she had to tell the truth. CNA #7 said Resident #6 suffered several days before the hospital realized her right hip was fractured because she failed to notify the Administrator.

During an interview on 7/13/21 at 11:00 AM, with CNA #8 revealed CNA #7 came to her and told her Resident #6 fell in her room on 7/2/21. CNA #7 told CNA #8 that RN #7 did not write an incident report or send Resident #6 to the hospital. CNA #8 told CNA #7 to write a statement and keep it just in case something happens to the Resident.

During an interview on 7/13/21 at 11:15 AM, with CNA #9 revealed CNA #7 told her that Resident #6 fell on the floor in her room on 7/2/21. CNA #7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 10	M 500		

said RN #7 would not send the resident to the hospital to be evaluated. RN #7 also did not write an incident report. CNA #9 said she told CNA #7 to write a statement to cover herself. CNA #9 said CNA #7 came to her because she has worked at the nursing home for a long time.

During an interview on 7/13/21 at 11:25 AM, with Licensed Practical Nurse (LPN) #2 said she received report from RN #7 on 7/2/21 at 3:00 PM. LPN #2 said while receiving report she heard somebody screaming. LPN #2 asked who is that? RN #7 said its Resident #6. RN #7 said Resident #6 was lowered to the floor today. RN #7 also said Resident # 6 vomited and complained of pain. LPN #2 said RN #7 gave Resident #6 something for pain and nausea. LPN# 2 said immediately after receiving report she checked on Resident #6 and noted she had vomited on her clothes. Resident #6 continued to yell out saying her back was hurting. LPN #2 called the Nurse Practitioner and received orders to send Resident #6 to the hospital to be evaluated.

During an interview on 7/13/21 at 11:40 AM, with the Administrator, revealed the Nurse Practitioner (NP) called her on 7/6/21 at 1:45 PM, from the local hospital stating Resident #6's x-ray results revealed a right hip fracture. The Administrator asked if Resident #6 had a fall during her stay at the hospital. The hospital records and staff did not report any falls or other incidents. The Administrator said she reported to the State Agency (SA) and Attorney General Office (AGO). The Administrator said she started an investigation immediately. The Administrator said the Director of Nursing (DON) called and questioned RN #7 and asked if Resident #6 had a fall on 7/2/21 before she went to the hospital. RN #7 told the DON that when she arrived on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 11	M 500		

shift the resident was in her wheelchair and had slid out but did not fall. Resident #6 was holding on to the chair with her bottom between the seat of the wheelchair and the floor. RN #7 said she did not do an incident report because she did not think it was a fall. RN #7 said CNA #7 helped her straighten Resident #6 in the wheelchair. RN # 7 was suspended pending investigation and was terminated after the investigation. RN# 7 was reported to the State Board of Nursing. The Administrator called CNA #7 and asked if Resident #6 fell on 7/2/21. CNA #7 said "no" Resident #6 did not fall. The Administrator asked CNA #7 for a statement in writing. The Administrator said CNA#7 came to the facility on 7/7/21 at 4:30 PM to talk to her. CNA #7 told the Administrator that on 7/2/21 around 8:00 AM, she was coming out of another resident's room when she heard Resident # 6 yell out "help me." CNA #7 said she found Resident #6 on the floor in her room by the bathroom door. CNA #7 called RN #7 to the room. RN # 7 asked if Resident #6 hit her head. CNA #7 stated " yes", because her head was against the wall. RN #7 said, "I don't have time for this, I'm not sending her out." CNA #7 and RN #7 assisted Resident #6 back in the wheelchair. Resident #6 continued to yell out in pain. Resident #6 was wheeled to the dayroom. CNA #7 said she checked on the resident all day. CNA #7 said she went back to RN #7 and asked if she would send Resident #6 out because she continues to complain of pain. RN #7 said she has had so many falls already, she doesn't have time to send her out. CNA #7 said after lunch Resident #6 vomited and complained of pain to her hip during Activities of Daily Living (ADL) care. CNA #7 told RN#7 and medication was administered for pain and nausea. CNA #7 also said RN #7 said the resident did not have any broken bones when she was sent out to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 12 hospital. CNA #7 said when she found out Resident #6 had a right hip fracture, she knew she had to tell the truth. CNA #7 said she told CNA #8 and CNA # 9 about the situation. Both CNAs told her to write a statement and keep, just in case something happened. CNA #7 was suspended pending investigation. Both CNAs were interviewed and confirmed CNA #7 did talk to them about Resident #6 fall and RN #7 refusing to write an incident report or send Resident #6 to the hospital for an evaluation. Both CNA's advised CNA #7 to write a statement and to keep it. The Administrator said she interviewed LPN #2.LPN#2 said she received in report from RN #7 that Resident #6 was lowered to the floor. LPN #2 said she sent Resident #6 to the hospital because she continued to vomit and complain of back pain. The Administrator called an emergency Quality Assurance Performance Improvement (QAPI) meeting on 7/8/2021. Record review of the facility's in-service dated 3/16/21 and 5/24/21 revealed Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 was educated on Abuse, Neglect, Misappropriation, and Exploitation.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 13	M 500		

Level III
Based on staff interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from neglect, related to a fall with injury for one (1) of five (5) residents reviewed. Resident #6.

Findings include:

Review of the facility "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms... Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.
...Neglect- failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress ... Staff will be supervised to identify inappropriate behaviors such as derogatory language; rough handling; ignoring residents while giving care; directing residents who need toileting assistance to urinate or defecate in their beds ..."

Record review of the "Admission Record" revealed Resident #6 was admitted on 8/12/20, with diagnoses that included Dementia, Transient Ischemic Attack (TIA), and Schizoaffective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 14	M 500		

disorder.

Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated Resident #6 has severe cognitive impairment.

Record review of the facility's "CES Quarterly Evaluation Bundle (Clinical-V11)" dated 5/12/21 revealed "2. Fall Risk Evaluation Instructions: If the score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Resident #6's Fall Risk Score was 21."

Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have copious amount of vomit in her bed ...Resident assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..."

Record review of the local hospital progress note dated 7/6/21 revealed " Patient was seen and examined today. Patient is a terrible historian. She constantly yells out with any movement of her right leg. Case was discussed with physical therapy. Imaging obtained."

Record Review of the local hospital x-ray report dated 7/6/21 revealed a displaced right femoral neck fracture.

Record review of the facility investigation dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 15 7/6/21, revealed there were no recent falls or incidents documented from the hospital. The investigation at the facility revealed that there was an incident regarding Resident #6 on 7/2/21. RN #7 and CNA #7 reported two different stories. RN #7 changed her story multiple times, did not document, and was reported to the state Board of Nursing by the facility. No other staff members were identified to have witnessed the incident. During an interview on 7/13/2021 at 10:30 AM, with RN #7 revealed she was called to Resident #6's room by CNA #7 on 7/2/2021 at 8:00 AM. RN #7 said Resident #6 was sitting in the wheelchair crooked. RN #7 said CNA # 7 helped her straighten the resident up in the wheelchair. RN # 7 said she suspected Resident # 6 must have fell and put herself in the wheelchair crooked. RN #7 said she did not do an incident report or notify anybody because she wasn't for sure if the resident fell. RN # 7 said Resident #6 has had several falls and complains of pain all the time. RN # 7 said Resident #6 vomited later during the day and complained of pain. RN #7 said she gave Resident #6 Zofran for nausea and a pain pill. Interview on 7/13/21 at 10:45 AM, with CNA #7 revealed on 7/2/21 at 7:00 AM she heard a resident scream "help.". CNA #7 said she saw Resident #6 on the floor. CNA # 7 said she called for RN#7. RN #7 asked CNA #7 if the resident hit her head. CNA #7 said she thinks she did because her head was against the wall. RN #7 said "I don't have time for this. I am not sending her out because she falls all the time. She's, ok". CNA #7 said she took the resident to the dining room after assisting RN #7 with putting her back in the wheelchair. CNA # 7 said Resident #6 was very confused, would not eat and complained of pain to her arm. CNA # 7 said CNA #8 was in the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 16	M 500		

dining room. CNA #8 asked CNA #7 if Resident #6 was OK. CNA #7 told CNA #8 that Resident #6 fell this morning in her room. CNA #7 also said RN #7 did not write an incident report, nor send the resident to the hospital for an x-ray. CNA #8 told CNA #7 to go back to RN #7 and write a statement to cover herself. CNA #7 said CNA #9 also asked during breakfast, what is wrong with Resident #6. CNA #7 said Resident #6 fell, and RN #7 did not write an incident report or send the resident to the hospital to be evaluated. CNA #9 also told CNA #7 to write a statement and keep it because the Administrator or somebody will come to her to find out what happen. CNA # 7 said Resident #7 continued to complain of pain. CNA #7 went to the nurse and said Resident #6 continues to complain of pain. CNA #7 told RN #7 that Resident #6 probably needs to go to the hospital. RN #7 refused to send her out. CNA # 7 said after lunch the resident vomited and continued to complain of pain to her back. CNA #7 said she cleaned the resident up and let RN #7 know the resident had vomited and complained of pain. RN #7 gave the resident something for pain and nausea. CNA #7 said when she came back to work the next day, she was told Resident #7 was sent to the hospital for vomiting and pain. CNA #7 said RN #7 came to her saying they need to get their story together. CNA #7 said she told the RN #7 that she wrote a statement. CNA #7 said a couple of days later the Administrator called her and ask if Resident #6 had a fall. CNA #7 said "no" Resident #6 did not fall. The Administrator asked her to write a statement and bring it to the facility. CNA # 7 said she came to the facility and talked to the Administrator. CNA #7 said she told the Administrator that she needed to tell the truth because she did not realize the resident had a fractured hip. CNA # 7 said she told the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 17	M 500		

Administrator that she heard Resident # 6 scream "help me." CNA #7 said she found Resident #6 on the floor. CNA #7 said she called RN #7 to the room. CNA #7 also stated that she told the Administrator that RN #7 refused to send the resident out to the hospital because she didn't have time and the resident always falls and complains of pain. CNA # 7 said she felt bad because RN #7 told her the Resident did not receive any broken bones and the Resident was ok. When she realized Resident #6 had a right hip fracture, she had to tell the truth. CNA #7 said Resident #6 suffered several days before the hospital realized her right hip was fractured because she failed to notify the Administrator.

During an interview on 7/13/21 at 11:00 AM, with CNA #8 revealed CNA #7 came to her and told her Resident #6 fell in her room on 7/2/21. CNA #7 told CNA #8 that RN #7 did not write an incident report or send Resident #6 to the hospital. CNA #8 told CNA #7 to write a statement and keep it just in case something happens to the Resident.

During an interview on 7/13/21 at 11:15 AM, with CNA #9 revealed CNA #7 told her that Resident #6 fell on the floor in her room on 7/2/21. CNA #7 said RN #7 would not send the resident to the hospital to be evaluated. RN #7 also did not write an incident report. CNA #9 said she told CNA #7 to write a statement to cover herself. CNA #9 said CNA #7 came to her because she has worked at the nursing home for a long time.

During an interview on 7/13/21 at 11:25 AM, with Licensed Practical Nurse (LPN) #2 said she received report from RN #7 on 7/2/21 at 3:00 PM. LPN #2 said while receiving report she heard somebody screaming. LPN #2 asked who is that?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 18 RN #7 said its Resident #6. RN #7 said Resident #6 was lowered to the floor today. RN #7 also said Resident # 6 vomited and complained of pain. LPN #2 said RN #7 gave Resident #6 something for pain and nausea. LPN# 2 said immediately after receiving report she checked on Resident #6 and noted she had vomited on her clothes. Resident #6 continued to yell out saying her back was hurting. LPN #2 called the Nurse Practitioner and received orders to send Resident #6 to the hospital to be evaluated. During an interview on 7/13/21 at 11:40 AM, with the Administrator, revealed the Nurse Practitioner (NP) called her on 7/6/21 at 1:45 PM, from the local hospital stating Resident #6's x-ray results revealed a right hip fracture. The Administrator asked if Resident #6 had a fall during her stay at the hospital. The hospital records and staff did not report any falls or other incidents. The Administrator said she reported to the State Agency (SA) and Attorney General Office (AGO). The Administrator said she started an investigation immediately. The Administrator said the Director of Nursing (DON) called and questioned RN #7 and asked if Resident #6 had a fall on 7/2/21 before she went to the hospital. RN #7 told the DON that when she arrived on her shift the resident was in her wheelchair and had slid out but did not fall. Resident #6 was holding on to the chair with her bottom between the seat of the wheelchair and the floor. RN #7 said she did not do an incident report because she did not think it was a fall. RN #7 said CNA #7 helped her straighten Resident #6 in the wheelchair. RN # 7 was suspended pending investigation and was terminated after the investigation. RN# 7 was reported to the State Board of Nursing. The Administrator called CNA #7 and asked if Resident #6 fell on 7/2/21. CNA #7 said "no"	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 19	M 500		

Resident #6 did not fall. The Administrator asked CNA #7 for a statement in writing. The Administrator said CNA#7 came to the facility on 7/7/21 at 4:30 PM to talk to her. CNA #7 told the Administrator that on 7/2/21 around 8:00 AM, she was coming out of another resident's room when she heard Resident # 6 yell out "help me." CNA #7 said she found Resident #6 on the floor in her room by the bathroom door. CNA #7 called RN #7 to the room. RN # 7 asked if Resident #6 hit her head. CNA #7 stated " yes", because her head was against the wall. RN #7 said, "I don't have time for this, I'm not sending her out." CNA #7 and RN #7 assisted Resident #6 back in the wheelchair. Resident #6 continued to yell out in pain. Resident #6 was wheeled to the dayroom. CNA #7 said she checked on the resident all day. CNA #7 said she went back to RN #7 and asked if she would send Resident #6 out because she continues to complain of pain. RN #7 said she has had so many falls already, she doesn't have time to send her out. CNA #7 said after lunch Resident #6 vomited and complained of pain to her hip during Activities of Daily Living (ADL) care. CNA #7 told RN#7 and medication was administered for pain and nausea. CNA #7 also said RN #7 said the resident did not have any broken bones when she was sent out to the hospital. CNA #7 said when she found out Resident #6 had a right hip fracture, she knew she had to tell the truth. CNA #7 said she told CNA #8 and CNA # 9 about the situation. Both CNAs told her to write a statement and keep, just in case something happened. CNA #7 was suspended pending investigation. Both CNAs were interviewed and confirmed CNA #7 did talk to them about Resident #6 fall and RN #7 refusing to write an incident report or send Resident #6 to the hospital for an evaluation. Both CNA's advised CNA #7 to write a statement and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 20 to keep it. The Administrator said she interviewed LPN #2.LPN#2 said she received in report from RN #7 that Resident #6 was lowered to the floor. LPN #2 said she sent Resident #6 to the hospital because she continued to vomit and complain of back pain. The Administrator called an emergency Quality Assurance Performance Improvement (QAPI) meeting on 7/8/2021. Record review of the facility's in-service dated 3/16/21 and 5/24/21 revealed Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 was educated on Abuse, Neglect, Misappropriation, and Exploitation.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide adequate staff supervision to prevent the elopements of Resident #1 and Resident #5 from the facility and prevent a fall for Resident #6 for three (3) of ten (10) sampled residents identified at risk for wandering/elopement and falls. Resident #1 left the facility unsupervised and was away for approximately 88 minutes when he was found lying on his back on the asphalt parking lot of the	M 640	1. Resident # 1 was assessed by Registered Nurse (RN) # 1 on 7/1/21 upon return to the facility with no signs of injury noted other than a few minor skin abrasions. Resident # 1 was placed on one-on-one monitoring from 7/1/21 until 7/2/21. On 7/2/21 Resident # 1 was placed on visual monitoring. Resident # 5 was assessed by RN # 1 on 7/14/21 upon return to the facility with no signs of injury noted. On 7/14/21 Resident # 5 was placed on one-on-one monitoring	8/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 21 building next door to the facility by a staff member who was walking by on the way to work and heard the Resident yell "hey". Resident #1 had minor abrasions of the left arm and leg, a quarter size bruise on the top of the left hand and a skin tear on the left knee. Resident #1 had been evaluated for wandering and elopement risk and identified as a resident with wandering behaviors and at risk for elopement by the facility prior to elopement. During the survey on 7/14/21, Resident # 5, admitted to the facility on 7/13/21 and identified as high risk for elopement, eloped from the facility for approximately 16 minutes and was found approximately 0.4 - 0.6 miles from the facility at his niece's house. To get to the location would have necessitated Resident #5 to walk along a row of commercial buildings on a busy road with continuous traffic and cross a four-lane highway. The facility's failure to provide supervision to prevent the elopements of Residents #1 and #5 and a fall for Resident #6 placed these residents and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 7/1/21, when the facility failed to provide adequate supervision to prevent the elopement of Resident #1. On 7/12/21 at 1:15 PM, the State Agency (SA) notified the Administrator of the IJ and SQC and provided the facility with the IJ Template. An additional IJ Template was provided on 7/14/21, when Resident #5 eloped. The facility submitted an acceptable Removal Plan on 7/15/21, in which they alleged all corrective actions to remove the IJ were completed on 7/15/21, and the IJ	M 640	until he was transported and discharged to Oceans Behavioral Health. Resident # 6 was sent to Hospital on 7/2/21. Upon return, on 7/16/21, Resident # 6 was assessed by the Director of Nursing (DON) and safety measures were put in place. 2. All residents in the facility with a risk for elopement have the potential to be affected by this practice. On 7/2/21 all residents who were identified as an Elopement/Wander Risk were reassessed for elopement risk and care plans were reviewed. There were ten (10) residents who were identified as an Elopement/Wander Risk. All residents identified at risk for elopement were placed on visual monitoring on 7/2/21 by the Director of Nursing (DON) and Minimum Data Set (MDS) Nurses. The MDS nurses reviewed and revised the care plans for all residents identified at risk for elopement on 7/2/21. On 7/2/21 the Maintenance Director secured the switch box cover located at the front door with a zip tie until 7/13/21 when a padlock was purchased and put in place of the zip tie to secure the front door. On 7/14/21 the MDS Nurse, DON, and Social Services Director (SSD) reassessed all residents for elopement risk, care plans were reviewed and revised as necessary. There were eleven (11) residents who were identified as an Elopement/Wander Risk. All care plans were reviewed, one revision was made on Resident # 5's care plan to reflect the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 22 removed on 7/16/21. The SA validated the Removal Plan on 7/17/21, and determined the IJ was removed on 7/16/21, prior to the exit. Therefore, the scope and severity for Rule 45.21.8 Accidents, was lowered to a Level III while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Elopement/Unsafe Wandering Plan", dated February 2012, revealed "It is the policy of this facility to protect the resident form harm while providing care in a manner that helps promote quality of life in a safe environment." Further review revealed, "Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary." Further review of the facility's policy, "Accidents and Incidents",(undated), revealed "It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible." An interview with the Administrator on 7/15/21 at 8:44 AM revealed the facility did not have a policy for supervision. Resident #1 Review of the facility's incident investigation dated and signed by the Administrator on 7/05/21, revealed on 7/01/21 at 10:41 PM CNA #1 phoned the facility to report that Resident #1 was outside the facility. Administrator's interviews with staff revealed Resident #1 had last been seen by staff	M 640	one-on-one. No other revisions were made. On 7/14/21 the Maintenance Director secured the laundry room door. On 7/15/21 Southern Fire and the Maintenance Director secured the exit door in laundry by a magnetic lock that requires a code to exit. On 7/8/21, the Social Services Director (SSD) and Life Connections Coordinator (LCC) spoke with all interviewable residents on regarding abuse and neglect to rule out any other incidents or concerns. No negative outcomes were reported. All Residents were assessed by the Minimum Data Set (MDS) nurses, Assistant Director of Nursing (ADON), and Director of Nursing (DON) on 7/8/21 for signs of abuse and neglect or incidents including falls by completing body audits and pain assessments; no negative outcomes were documented. 3. All staff were in-serviced beginning on 7/2/21 and ending 7/6/21 regarding elopement policies, yellow identification arm bands, elopement books, visual monitoring, and ensuring privacy when entering door codes by the Administrative Staff to include the Administrator, Director of Nursing (DON), Business Office Manager (BOM)/HR, Admissions Coordinator, Social Services Director (SSD), Restorative Licensed Practical Nurse, and 3-11 Supervisor Registered Nurse. All staff will receive in-service regarding elopement policies upon hire beginning 7/2/21. The Minimum Data Set (MDS) Nurses or DON will ensure all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 23 at approximately 9:02 PM at the South Hall Nurses station where he came to get his evening medicine. Resident #1 was safety returned to the facility by staff. Resident #1 reported he exited the building to go to the pharmacy to get some pain medicine for right shoulder pain. Facility staff were able to determine the resident exited through the front door by using his came to disable the magnetic locking mechanism on the door. An immediate assessment by Registered Nurse (RN) #1 was completed and injuries included skin abrasions to the side of the left arm and leg, a quarter sized bruise on the top of the resident's left hand and skin tear to right knee, none of which required medical attention and were treated at the facility. Resident #1 had been evaluated for wandering and elopement risk and identified as a resident with wandering behaviors and at risk for elopement by the facility prior to elopement. Resident #1 was immediately assessed and placed on 1: 1 monitoring. The Administrator's interview with Resident #1 revealed he stated he went out the exit door next to the laundry, however, upon investigation the "security" switch on the front door was found to be capable of being manipulated into disarming the magnetic lock on the front door. Resident #1 then stated he went out the front door and propelled himself in his wheelchair along the sidewalks of the facility and the building next door and across the parking lot of that building. Resident #1 reported that in an effort to cross a grassy strip between the building next to the facility and the next building his wheelchair wheels got stuck in the moist ground causing him to slide out of the wheelchair and he could not get himself back into the wheel chair. The Maintenance Supervisor was able to identify a previously unknown characteristic of the "security" switch on the front door and was able to	M 640	residents are evaluated upon admission for elopement risk and placed on visual monitoring beginning 7/2/21. The MDS nurses will evaluate all residents for elopement risk quarterly and with significant changes and place on visual monitoring as needed beginning on 7/2/21. The Administrator completed a one-on-one in-service with the Maintenance Director and the Maintenance Assistant on 7/15/21 regarding exit doors and barriers- if either of them finds an exit door or barrier is not functioning properly, they must report it to the Administrator immediately. On 7/8/21 the Administrator, Director of Nursing (DON), Nurse Supervisor, and Business Office Manager (BOM)/ HR completed an in-Service with all nurses regarding incidents/accidents, assessing, documentation, and reporting. On 7/8/21 the Administrator, DON, Nurse Supervisor, and BOM/HR completed an in-service with all staff regarding reporting accidents, reporting abuse, neglect, chain of command, and when to call protocol. An elopement drill was successfully completed on 7/13/21. 4. The Minimum Data Set (MDS) Nurses, Social Services Director (SSD), Director of Nursing (DON), or Administrator will audit wander bracelets of all residents identified at risk for elopement weekly for six (6) months beginning on 7/9/21. Any concerns found will be documented and addressed immediately. MDS Nurses will audit records of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 24 secure the "security" switch at the front door. Resident # 1 was changed from 1:1 monitoring to visual checks every thirty (30) minutes on 7/02/21 following Quality Assessment and Performance Improvement (QAPI) committee meeting. State Agency was notified on 7/02/21 at 1:59 AM by the Administrator. After investigation, interview with the resident and staff revealed the resident was very knowledgeable and aware of his actions and able to exit the facility. Resident #1 was returned to the facility at Approximately 10:50 PM. Skin abrasions to Resident #1's left arm and leg, a quarter sized bruise on the top of the resident's left hand and skin tear to right knee were noted upon return to the facility. Resident #1 was assisted to return to the facility and placed on one on on (1:1) supervision. Resident #1 reported he left the facility to go to the pharmacy to get some pain medicine for his right shoulder. Resident #1 was immediately placed on one on one (1:1) monitoring with staff. The Medical Doctor (MD) was notified. Resident #1's Responsible Party (RP) was notified. Observations on 7/08/21 at 10:40 PM revealed well maintained sidewalks and parking lots with lots of street lights and signs that provided light to the fairly well lit area. The terrain was flat. The posted speed limit on the street was thirty-five miles per hour (35 mph). The traffic was light with eighteen (18) cars observed to pass the nursing home in three (3) minutes between 10:31 PM and 10:34 PM. The resident was located 44 feet from the street. Resident #1 propelled himself in his wheelchair 700 feet from the facility. Record review of AccuWeather, an Internet weather forecasting site, revealed the weather for the city on 7/01/21 was partly cloudy, seventy-three (73) degrees Fahrenheit with	M 640	residents identified at risk for elopement monthly to ensure visual monitoring is in place beginning August 2021. Any concerns found will be documented and addressed immediately. The Administrator will conduct elopement drills on various shifts monthly for a period of 3 months beginning 8/5/21 to end on 11/5/21. Any concerns found will be documented and addressed immediately. It is the facility's practice to input all incidents as they occur in the risk management section of Point Click Care (PCC) by nursing and for it to be reviewed by the Minimum Data Set (MDS) Nurses, Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Managers, or Administrator for interventions to be implemented to be reviewed for an ongoing basis. The Maintenance Director or Maintenance Assistant will complete an audit of door checks to include checking all exit door itself, the keypads, magnets, and alarms to ensure proper operational functions weekly to begin on 7/19/21. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 6 months to end on January 2, 2022. The first QAPI meeting to review such audits will be held in August 2021. If the Quality Assurance Team identifies concerns or non-compliance, the team will review policies and procedures and submit solutions and/or changes to make as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 25 ninety-seven percent (97%) humidity. On 7/08/21 at 10:40 PM, an interview with RN #1, who was the resident's nurse on the evening 7/01/21, revealed the last time RN #1 saw the resident was at approximately 9:02 PM at the South Hall nurses station when he came to get his evening medicine. RN #1 stated it was not unusual for the resident to come to the nurses desk for his evening medication. RN #1 stated that Resident #1 had not complained of pain. RN #1 stated she saw him roll away "down the hall" but did not notice where he went. RN #1 stated the resident habitually "wandered with purpose" in the facility, but not aimlessly and she had never seen him attempt to exit the facility unaccompanied. RN #1 stated when LPN #1 received call from CNA #1 at 10:41 PM and "shouted for the nurse" and told her Resident # 1 was outside, RN #1 and LPN #1 immediately went to the resident, did a quick assessment, assisted the resident to return to the facility, performed a more thorough assessment, and assisted the resident into bed per his request, notified the DON, began 1:1 monitoring of the resident, conducted a check of all exit doors and performed a one hundred percent (100%) headcount of all residents, and notified the Resident's Responsible Party and his doctor. RN #1 stated all exit doors were locked and secure and all residents were accounted for. RN #1 stated "he won't keep that I.D. bracelet on". RN #1 confirmed the only observation scheduled for Resident #1 prior to 7/01/21 was one time each shift "Resident is to wear yellow wander barcelet (bracelet). Check for Placement every shift." dated 2/14/19. RN #1 stated Resident #1's PRN (as needed) pain medicine had been discontinued on 7/01/21 and he had been upset about it earlier in the day. RN ##1 stated the PRN	M 640	needed. Completion date as of 8/24/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 26	M 640		

pain medicine was prescribed again for Resident #1 with instructions that the medicine be crushed prior to administration. RN #1 reported Resident #1 is now on "hourly visual checks that are documented on the MAR (Medication Administration Record)".

On 7/08/21 at 10:50 PM, an interview with CNA #1 revealed she was scheduled to work the 11:00 PM to 7:00 AM shift at the facility and was walking to work, as was her routine, on the evening of 7/01/21. CNA #1 stated at approximately 10:30 PM as she approached the building next to the facility she heard someone yell "Hey" and looked and recognized Resident #1 laying on his back on the asphalt parking lot of the building next to the facility. CNA #1 stated she immediately went to the resident, asked him if he was hurt, "looked him over for obvious injury", asked him why he was outside and how he got outside, stayed with the resident and phoned the facility. CNA #1 stated RN #1 and LPN #1 "were there almost instantly". CNA #1 reported having assisted the resident into his wheelchair and returning him to the facility without difficulty. CNA #1 stated she was familiar with Resident #1 and had seen him wandering in the facility but had never seen him attempt to exit the facility unaccompanied. CNA #1 stated she was scheduled to work in a different area and reported to her assigned area.

On 7/08/21 at 11:05 PM, an interview with LPN #1 revealed she was working North Hall on the evening of 7/01/21 and answered a telephone call at approximately 10:41 PM from CNA #1 who reported Resident #1 was outside in the parking lot of the building next to the facility. LPN #1 stated she immediately went to the South Hall nurses station shouted for the nurse and went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 27	M 640		

immediately with RN #1 to the location described by CNA #1. LPN #1 stated Resident #1 was quickly assessed, assisted to return to the facility,more thoroughly assessed and assisted into bed per his request. RN #1 confirmed that all exits were checked and found to be locked and secure and a 100% head count was performed with all residents accounted for. LPN stated she was familiar with Resident #1 and his care and had seen him wander in the facility frequently but never saw him attempt to exit the facility unaccompanied.

On 7/08/21 at 11:20 PM, an interview with Director of Nurses (DON) revealed she had been notified by phone at approximately 10:45 PM that Resident #1 had been located outside at the building next to the facility. DON stated she immediately notified the Administrator. DON reported having seen Resident #1 wandering in the facility routinely but never saw him attempt to exit the facility unaccompanied. DON stated Resident #1 had visited her office earlier in the afternoon of 7/01/21 and indicated concern about the discontinuation of his PRN pain medicine. The DON stated she had explained the medicine change and Resident had "remained calm, indicated that he understood and not got upset".

On 7/09/21 at 10:20 AM, an interview with the Social Services Director (SSD) revealed she was involved in the development of the resident's care plan and attended his care plan meetings, was involved in the development of his behavior management plan to address the elopement, attended the QAPI meeting on 7/02/21 at 4:00 PM. SSD stated she was "responsible for maintaining the elopement books and identification bracelets". SSD stated she had seen Resident #1 wandering in the facility many

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 28	M 640		

times but had never seen him attempt to exit the facility unaccompanied. SSD stated that on 7/02/21 Resident #1 showed her the route he had taken after exiting the facility front door alone on the evening of 7/01/2. SSD stated Resident #1 indicated he left the facility to go to the pharmacy for some pain medicine. SSD stated she had been aware Resident #1 was not compliant with wearing the yellow identification bracelet and in response she had "encouraged him to wear it and got him to put it back on when he would".

On 7/09/21 at 10:28 AM, an interview with Resident #1 revealed he was calm, cooperative and oriented to date and time and recalled the elopement when he was asked and reported he had left the facility to go to the pharmacy and get some pain medicine for right shoulder pain. Resident #1 confirmed he had exited the front door of the facility and pantomimed use of his cane to manipulate the "security" switch and disable the magnetic lock and the use of his left arm to push the door open. Resident #1 confirmed he had exited the building shortly after taking his evening medicine. Resident #1 confirmed he did not report pain to staff on the evening of 7/01/21. Resident #1 stated he had lain on the asphalt a "long time". Resident #1 stated he had no lingering effects or bad feelings related to the elopement and staff had not treated him any differently since the elopement.

Record review of the Admission Record revealed Resident #1 was originally admitted to the facility on 1/27/12 with the most recent readmission of 1/12/18. Diagnoses included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affected right dominant side, Unspecified Dementia without behavioral disturbance, Pain in right shoulder, Type 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 29 Diabetes Mellitus and Epilepsy. Record review of Resident #1's Order Summary Report dated 7/9/21 revealed Resident #1 had order for "Resident is to wear yellow wander bracelet. Check for Placement every shift" initiated 2/14/19. Resident #1's most recent Minimum Data Set (MDS), dated 5/05/21 revealed a Brief Interview for Mental Status (BIMS) score was 15 which indicated no cognitive impairment On 7/09/21/21 at 11:00 AM an interview with the Maintenance Supervisor revealed he had reported to the facility "right before midnight" on 7/01/21, assessed the locking system and "made sure all the exit doors opened and locked back" and then discovered "the switch above the front door that is used to lock the door on the outside could be switched off and back on and will unlock the door for ten (10) to fifteen (15) seconds. The Maintenance Supervisor stated he "put the zip tie in place to prevent the door housing the switch from opening without the code being punched into the keypad". The Maintenance Supervisor stated he kept a log to document the weekly checks performed on all exit doors weekly. On 7/09/21 at 11:20 AM an interview with the Administrator revealed she and the Maintenance Supervisor met at the facility at approximately 12:00 AM on 7/02/21, assessed all exit doors to ensure they were locked and secure. The Administrator stated the Maintenance Supervisor "discovered the switch above the front door that is used to lock the door on the outside could be switched off and back on and will unlock the door for ten (10) to fifteen (15) seconds. The resident could reach that switch with his cane, just like he	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 30	M 640		

demonstrated.". The Administrator stated the Maintenance Supervisor secured the cover of the box the switch is in with a zip tie". The Administrator stated Resident #1 was placed on one on one (1:1) supervision to prevent further elopements.

On 7/09 at 3:00 PM an interview with facility Medical Director revealed he attended via teleconference a QAPI committee meeting on 7/02/21 at 4:00 and the committee reviewed the policy for elopement and missing persons to ensure it does not happen again.

On 7/09/21 at 10:20 AM an interview with SSD and the Administrator, and observation of the facility floor plan and the area surrounding the facility revealed there was a three inch wide, five inch long (3'x5') opaque plastic box with a hinged door mounted on the wall to the left inside the facility's front door six feet (6') above the floor. Inside the box was a switch that looked like a regular light switch that would be on the wall to turn the light in a room on/off. There was a zip tie which secured the door of the box closed which SA observed replaced by a lock which required a key to open. SSD explained how when asked to show her where he exited the building and where he had gone the resident took her on a tour beginning at the front door where he demonstrated how he had used his cane to manipulate the switch to open the door, pushed open the door, propelled himself along the sidewalk of the facility and the building next door and stopped at the grassy strip between the building next door and the building two doors down. Staff were not aware the resident was out of the building until they received a call from CNA #1 that the resident was in the parking lot of the building next door. The Administrator confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 31	M 640		

that the facility does not have cameras inside or outside the building. They determined the distance from the front door of the facility to the location where the resident was located was 700 feet.

Resident #5:

On 7/14/21 at 9:04 AM, observation revealed facility initiated a "Code Orange" Alert for Resident #5. SA was in the facility activity room when "Code Orange" was announced on the overhead announcement system. Staff was observed searching for the resident. SA spoke with Registered Nurse (RN) #7 who confirmed the event was an actual elopement of a resident.

7/14/21 at 9:08 AM observation revealed SA walking along the hallway was able to open the door to the laundry, walked inside the laundry room and did not see anyone in the laundry.

On 7/14/21 at 9:40 AM observation revealed the elopement binders labeled "wander books" at the South Hall nurses' station and at the North Hall nurses' station did not contain a sheet for Resident #5.

On 7/14/21 at 10:00 AM an interview with the Administrator revealed Resident #5 had been admitted on 7/13/21 and had been assessed and identified as an elopement risk. The Administrator stated that to her knowledge, Resident #5 had made no attempts to leave the facility. The Administrator acknowledged Resident #5's information and photo are not in the "Wander Books" (elopement binders) located at each nurses' station to alert staff of residents identified as elopement risks. The Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 32 Resident #5 refused to wear the yellow identification bracelet but had agreed to wear a yellow lanyard with identification card. On 7/14/21 at 10:08 AM an interview with the Care Plan Nurse, RN #3 revealed she had entered a care plan for risk of elopement for Resident #5 because when he arrived at the facility on 7/13/21 he was ready to leave and was trying to leave because he wanted to go home. RN #3 stated she had not witnessed Resident #5 going to the door but had seen him standing in the front area and he was wanting to leave. RN #3 stated Resident #5 refused to wear the yellow identification bracelet and was provided with a yellow lanyard and identification card. RN #3 stated staff knew which residents had wandering behaviors because staff were required to document hourly visual checks and that the yellow identification bracelet or lanyard was in place on the Medication Administration Record (MAR). RN #3 stated she was responsible for setting up the hourly checks on the MAR so staff could document hourly visual observations and she was also responsible for setting up the hourly checks on the Certified Nursing Assistant (CNA) Tasks so the CNA's could document visual checks. On 7/14/21 at 10:15 AM, an interview with the Social Services Director (SSD) revealed it was her responsibility to update the elopement binders (labeled "Wander Book"). SSD stated it takes a while to get a new admission into the system and she was unable to get a photograph of Resident #5, so she did not get his information out to the nurses stations. The SSD admitted she did not put Resident #5's information in the elopement binders.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 33 On 7/14/21 at 10:45 AM an interview with Resident #5 in his room revealed he was calm and cooperative and when asked about leaving the facility without notification he responded "I love to walk. I can go out and walk all over the place and not hurt nothing. All I did was touch the door and it opened". When asked if anyone exited before him Resident #5 answered "no". When asked if he had been told the code to the keypad to open the door Resident #5 answered "no". When asked if he had gotten hot while outside Resident #5 responded "No, I walk everywhere." On 7/14/21 at 12:30 PM SA drove from the facility to the address where Resident #5 was located after elopement. The address was four tenths (0.4) of a mile away from the facility. SA observed a row of commercial building on a road busy with continuous traffic. There was no way for the Resident #5 to get to the address where he was located without crossing a four-lane road that was also busy with continuous traffic with no noted crosswalks. SA determined it was too dangerous to walk the route. Record review of AccuWeather, an Internet weather forecasting site, revealed the documented weather temperature for the city on 7/14/21 was approximately 89 degree and sunny. 7/14/21 at 1:17 PM interview with Licensed Practical Nurse (LPN) #1 revealed worked on North Hall from 3:00 PM to 11:00 PM on Tuesday 7/13/21 and was Resident #5's nurse. LPN #1 described Resident #5 on Tuesday 7/13/21 as "pretty much ready to leave." LPN #1 reported Resident #5 stated that he was "supposed to have been taken to Biloxi, not here". LPN #1 stated Resident #5 was acting anxious and	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 34	M 640		

restless on 7/13/21. LPN #1 reported "I gave the resident his medicine at around 9:30 PM then he went to his room and stayed in his room where he remained until I got off work and left". LPN #1 stated she arrived at work on 7/14/21 at 7:00 AM for an eight (8) hour shift on North green ("Resident's room is on North pink"). LPN #1 stated "the last time I laid eyes on him was about 8:55 AM and he was asking about where his room was. I showed him where his door was, and he went into his room." LPN #1 stated that on 7/14/21 "A Code Orange was called for him and it was about five (5) minutes that I looked for him before I was told he had been found at his niece's house." LPN #1 stated no one had made her aware Resident #5 was an elopement risk but that she would know if residents were elopement risks due to monitoring on the Medication Administration Record (MAR) and the "Wander Books", and by observing resident behaviors.

7/14/21 at 2:00 PM an interview with RN #7 along with observation revealed the facility had investigated the elopement of Resident #5 and had determined that Resident #5 was able to exit the building through the laundry due to a malfunction of the self-closing/self-locking mechanism on the door between the hallway and the laundry room. RN #7 demonstrated the door, shut but not completely closed, was able to be pushed open. Further observation revealed upon entering the laundry room from the hallway there was another door located to the right with a sign that stated, "Keep Door Closed". RN #7 demonstrated how the second door led into the "dirty" area of the laundry department where an unlocked glass door directly to the left is located with no alarm or keypad that required a code for exit. The glass door exited directly outside to the backyard of the building in an area not fenced or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 35	M 640		

gated.

7/14/21 at 2:11 PM, interview with CNA #3 revealed she was assigned to Resident #5 for the 7:00 AM to 3:00 PM shift on 7/14/21 and stated, "Soon as I got out of my car other staff members were out in the parking lot and told me that he was missing, and I immediately started looking for him". CNA #3 stated that she had gone with CNA #6 and the Admission Coordinator in the facility van "to pick him up from his niece's house" where the Admission Coordinator talked with him about returning to the facility. When asked, CNA #3 stated she would know if residents were elopement risks due to care instructions on the "CNA Tasks" on the kiosks.

On 7/14/21 at 2:30 PM, interview with Housekeeping Staff #1 (Laundry Supervisor) revealed she was aware the door did not always close completely and lock, and that it had been an occasional issue for the two years she had worked at the facility. Housekeeping Staff #1 stated she had seen the current Maintenance Supervisor work on the self-closing/self-locking mechanism of the door from the hallway into the laundry room at least twice and the previous Maintenance Supervisor at least once over the past two (2) years. Laundry Supervisor stated she "reported any problems with the door to the Maintenance Supervisor who would work on it and fix it". Laundry Supervisor stated she had never seen a resident in the laundry room. Laundry Supervisor stated she had never seen a resident open the door between the hallway and the laundry room.

On 7/14/21 at 2:35 PM interview with Housekeeping Staff #2 (Laundry Tech) revealed she was not aware the door did not always close

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 36	M 640		

completely. Housekeeping Staff #2 stated she had worked at the facility for eighteen (18) years and had been trained to "always pull the door handle to make sure it was locked after exiting the door from the laundry into the hallway". Housekeeping Staff stated she had never seen a resident in the laundry room. Housekeeping Staff stated she had never seen a resident open the door between the hallway and the laundry room.

On 7/14/21 at 2:36 PM, a telephone interview with the niece (of Resident #5) revealed Resident #5 had walked up to her home between 8:55 AM and 9:00 AM. She stated, "he seemed ok" and was holding a milk carton. The niece reported Resident #5 had always walked around town, but his family had noticed a recent increase in confusion.

On 7/14/21 at 2:42 PM, a telephone interview with the Responsible Party (RP) for Resident #5 revealed Resident #5 had started having issues with confusion and dementia and recently the family noticed a decline because of the dementia. The RP stated he had signed the admission paperwork and had talked with the Admission Coordinator. The RP stated he was told by the Admission Coordinator that the facility "had the capacity to keep him locked in" and that is why he was so surprised the resident had walked to his niece's house.

7/14/21 at 2:42 PM, an interview with CNA #4 revealed she had delivered his breakfast tray to Resident #5 in his room at approximately 8:00 AM. Resident #5 immediately awoke and started putting on his shoes and CNA #4 went to continue to pass out breakfasts to residents. CNA #4 stated, "It was almost 9:00 (AM) and I was picking up the trays in the common area on North

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 37 Hall and he walked by me and said he would rather be in jail. The nurse was looking for him about five (5) minutes later". On 7/14/21 at 2:44 PM an interview with RN #1 revealed she arrived to work 7:00 AM to 3:00 PM on North Hall which included Resident #5. RN #1 reported after beginning the "7:00-10:00AM" medication pass she was at her medication cart and Resident #5 waked out of his room and was walking back and forth in the hallway and was talking to himself. RN #1 stated she did not recall seeing Resident #5 at the exit doors or involved in exit seeking behavior. The last time RN #1 saw Resident #5 was around 8:50 AM-8:55 AM on North wing. RN #1 stated she went into a resident room to provide care and upon returning to the hallway noted Resident #5 was not in the hall. RN #1 stated she went up to the office of the Admission Coordinator and asked if she had seen the Resident #5, but the Admissions Coordinator stated no she had not. RN #1 then told the DON she was looking for the resident. RN #1 stated "The staff searched for a few minutes and then the DON called the code". RN #1 stated she "kept on looking until he was located, and we got the all clear". RN #1 reported when Resident #5 returned to the facility she assessed him and found no injuries and the resident voiced no complaints. RN #1 stated that she would know if residents were elopement risks due to the "Wander Book", monitoring on the Medication Administration Record (MAR) and by observing resident behavior. On 7/14/21 at 3:28 PM, interview with CNA #5 revealed breakfast trays came out and she was passing out breakfast trays when Resident #5 approached her an began to tell her he had to "get out of here" but he went back to room his	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 38	M 640		

room and CNA #5 went to feed dependent residents. CNA #5 stated "it was only about five (5) minutes before his nurse was looking for him and said she was wanted to locate him because he was not in his room or the hallway". CNA #5 stated she searched the building and went outside and looked and did not stop looking until she heard the "all clear" that the resident had been located. CNA #5 stated no one told her the resident was an elopement risk. CNA #5 stated she would know if residents were elopement risks due to care instructions on the "CNA Tasks" on the kiosks. CNA #5 stated the facility is constantly having in-services about elopement.

On 7/14/21 at 4:40 PM interview with CNA #6 revealed she had clocked in at 8:35 AM and immediately encountered Resident #5 in the hallway near the time clock holding a milk carton "like the residents get with breakfast" CNA #6 stated Resident #5 told her "Someone has got to let me out of here". CNA #6 revealed she immediately went to the office of the Social Services Director and reported the resident's behavior. CNA #6 stated that 8:59 AM she was notified that the DON was looking for Resident #5 and she began to look for him also. CNA #6 reported having driven the facility van accompanied by the Admission Coordinator and CNA #3 to the resident's niece's home to return the resident to the facility. CNA #6 stated upon arrival at the facility Resident #5 had the demeaner of being calm and cooperative and returned to the facility for the nurse to do an assessment. CNA #6 stated Resident #5 was wearing dark blue jeans, a dark T-shirt, gray socks, and black tennis shoes.

On 7/15/21 at 8:40 AM interview with Administrator revealed she had been the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 39 Administrator for approximately one (1) year. The Administrator revealed Resident #5 was admitted from home following referral to the facility by his primary physician. The Administrator stated when the facility had a long-term care (LTC) referral, viability of the referral was determined by the facility staff. The Administrator stated she had not been made aware of any concerns related to Resident #5's risk of elopement prior to admission. The Administrator stated she had not been aware of any problems with the self-closing/self-locking mechanism of the door between the hallway and the laundry room. On 7/15/21 at 9:00 AM interview with Director of Nurses (DON) revealed a "Risk Assessment" was performed on every new admission to the facility which included Resident #5. The DON revealed the "Risk Assessment" for Resident #5's result was "High Risk" for elopement. The DON stated the staff would have been made aware of Resident #5's "High Risk for Elopement" status by "implementation on Medication Administration Record (MAR) and "CNA Tasks" on the kiosks". The DON stated she does not remember being made aware of any problems with the self-closing/self-locking door between the hallway and the laundry, and she does not remember being aware of the Maintenance Supervisor working on the door. The DON stated she does not remember ever seeing the door between the hallway and the laundry not fully closed or ever seeing any resident inside the laundry. DON stated the (elopement) "Wander" books at the nurses' stations "should be kept updated" as a mea Resident #6 Review of the facility "Freedom from Abuse,	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 40	M 640		

Neglect, and /or Exploitation Prevention Plan" revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms... Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.
...Neglect- failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress ... Staff will be supervised to identify inappropriate behaviors such as derogatory language; rough handling; ignoring residents while giving care; directing residents who need toileting assistance to urinate or defecate in their beds ..."

Record review of the "Admission Record" revealed Resident #6 was admitted on 8/12/20, with diagnoses that included Dementia, Transient Ischemic Attack (TIA), and Schizoaffective disorder.

Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated Resident #6 has severe cognitive impairment.

Record review of the facility's "CES Quarterly Evaluation Bundle (Clinical-V11)" dated 5/12/21 revealed "2. Fall Risk Evaluation Instructions: If the score is 10 or greater, the resident should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 41	M 640		

considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Resident #6's Fall Risk Score was 21."

Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have copious amount of vomit in her bed ...Resident assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..."

Record review of the local hospital progress note dated 7/6/21 revealed " Patient was seen and examined today. Patient is a terrible historian. She constantly yells out with any movement of her right leg. Case was discussed with physical therapy. Imaging obtained."

Record Review of the local hospital x-ray report dated 7/6/21 revealed a displaced right femoral neck fracture.

Record review of the facility investigation dated 7/6/21, revealed there were no recent falls or incidents documented from the hospital. The investigation at the facility revealed that there was an incident regarding Resident #6 on 7/2/21. RN #7 and CNA #7 reported two different stories. RN #7 changed her story multiple times, did not document, and was reported to the state Board of Nursing by the facility. No other staff members were identified to have witnessed the incident.

During an interview on 7/13/2021 at 10:30 AM, with RN #7 revealed she was called to Resident #6's room by CNA #7 on 7/2/2021 at 8:00 AM. RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 42 #7 said Resident #6 was sitting in the wheelchair crooked. RN #7 said CNA # 7 helped her straighten the resident up in the wheelchair. RN # 7 said she suspected Resident # 6 must have fell and put herself in the wheelchair crooked. RN #7 said she did not do an incident report or notify anybody because she wasn't for sure if the resident fell. RN # 7 said Resident #6 has had several falls and complains of pain all the time. RN # 7 said Resident #6 vomited later during the day and complained of pain. RN #7 said she gave Resident #6 Zofran for nausea and a pain pill. Interview on 7/13/21 at 10:45 AM, with CNA #7 revealed on 7/2/21 at 7:00 AM she heard a resident scream "help.". CNA #7 said she saw Resident #6 on the floor. CNA # 7 said she called for RN#7. RN #7 asked CNA #7 if the resident hit her head. CNA #7 said she thinks she did because her head was against the wall. RN #7 said "I don't have time for this. I am not sending her out because she falls all the time. She's, ok". CNA #7 said she took the resident to the dining room after assisting RN #7 with putting her back in the wheelchair. CNA # 7 said Resident #6 was very confused, would not eat and complained of pain to her arm. CNA # 7 said CNA #8 was in the dining room. CNA #8 asked CNA #7 if Resident #6 was OK. CNA #7 told CNA #8 that Resident #6 fell this morning in her room. CNA #7 also said RN #7 did not write an incident report, nor send the resident to the hospital for an x-ray. CNA #8 told CNA #7 to go back to RN #7 and write a statement to cover herself. CNA #7 said CNA #9 also asked during breakfast, what is wrong with Resident #6. CNA #7 said Resident #6 fell, and RN #7 did not write an incident report or send the resident to the hospital to be evaluated. CNA #9 also told CNA #7 to write a statement and keep it because the Administrator or somebody will come	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 43	M 640		

to her to find out what happen. CNA # 7 said Resident #7 continued to complain of pain. CNA #7 went to the nurse and said Resident #6 continues to complain of pain. CNA #7 told RN #7 that Resident #6 probably needs to go to the hospital. RN #7 refused to send her out. CNA # 7 said after lunch the resident vomited and continued to complain of pain to her back. CNA #7 said she cleaned the resident up and let RN #7 know the resident had vomited and complained of pain. RN #7 gave the resident something for pain and nausea. CNA #7 said when she came back to work the next day, she was told Resident #7 was sent to the hospital for vomiting and pain. CNA #7 said RN #7 came to her saying they need to get their story together. CNA #7 said she told the RN #7 that she wrote a statement. CNA #7 said a couple of days later the Administrator called her and ask if Resident #6 had a fall. CNA #7 said "no" Resident #6 did not fall. The Administrator asked her to write a statement and bring it to the facility. CNA # 7 said she came to the facility and talked to the Administrator. CNA #7 said she told the Administrator that she needed to tell the truth because she did not realize the resident had a fractured hip. CNA # 7 said she told the Administrator that she heard Resident # 6 scream "help me." CNA #7 said she found Resident #6 on the floor. CNA #7 said she called RN #7 to the room. CNA #7 also stated that she told the Administrator that RN #7 refused to send the resident out to the hospital because she didn't have time and the resident always falls and complains of pain. CNA # 7 said she felt bad because RN #7 told her the Resident did not receive any broken bones and the Resident was ok. When she realized Resident #6 had a right hip fracture, she had to tell the truth. CNA #7 said Resident #6 suffered several days before the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 44	M 640		

hospital realized her right hip was fractured because she failed to notify the Administrator.

During an interview on 7/13/21 at 11:00 AM, with CNA #8 revealed CNA #7 came to her and told her Resident #6 fell in her room on 7/2/21. CNA #7 told CNA #8 that RN #7 did not write an incident report or send Resident #6 to the hospital. CNA #8 told CNA #7 to write a statement and keep it just in case something happens to the Resident.

During an interview on 7/13/21 at 11:15 AM, with CNA #9 revealed CNA #7 told her that Resident #6 fell on the floor in her room on 7/2/21. CNA #7 said RN #7 would not send the resident to the hospital to be evaluated. RN #7 also did not write an incident report. CNA #9 said she told CNA #7 to write a statement to cover herself. CNA #9 said CNA #7 came to her because she has worked at the nursing home for a long time.

During an interview on 7/13/21 at 11:25 AM, with Licensed Practical Nurse (LPN) #2 said she received report from RN #7 on 7/2/21 at 3:00 PM. LPN #2 said while receiving report she heard somebody screaming. LPN #2 asked who is that? RN #7 said its Resident #6. RN #7 said Resident #6 was lowered to the floor today. RN #7 also said Resident # 6 vomited and complained of pain. LPN #2 said RN #7 gave Resident #6 something for pain and nausea. LPN# 2 said immediately after receiving report she checked on Resident #6 and noted she had vomited on her clothes. Resident #6 continued to yell out saying her back was hurting. LPN #2 called the Nurse Practitioner and received orders to send Resident #6 to the hospital to be evaluated.

During an interview on 7/13/21 at 11:40 AM, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 45	M 640		

the Administrator, revealed the Nurse Practitioner (NP) called her on 7/6/21 at 1:45 PM, from the local hospital stating Resident #6's x-ray results revealed a right hip fracture. The Administrator asked if Resident #6 had a fall during her stay at the hospital. The hospital records and staff did not report any falls or other incidents. The Administrator said she reported to the State Agency (SA) and Attorney General Office (AGO). The Administrator said she started an investigation immediately. The Administrator said the Director of Nursing (DON) called and questioned RN #7 and asked if Resident #6 had a fall on 7/2/21 before she went to the hospital. RN #7 told the DON that when she arrived on her shift the resident was in her wheelchair and had slid out but did not fall. Resident #6 was holding on to the chair with her bottom between the seat of the wheelchair and the floor. RN #7 said she did not do an incident report because she did not think it was a fall. RN #7 said CNA #7 helped her straighten Resident #6 in the wheelchair. RN # 7 was suspended pending investigation and was terminated after the investigation. RN# 7 was reported to the State Board of Nursing. The Administrator called CNA #7 and asked if Resident #6 fell on 7/2/21. CNA #7 said "no" Resident #6 did not fall. The Administrator asked CNA #7 for a statement in writing. The Administrator said CNA#7 came to the facility on 7/7/21 at 4:30 PM to talk to her. CNA #7 told the Administrator that on 7/2/21 around 8:00 AM, she was coming out of another resident's room when she heard Resident # 6 yell out "help me." CNA #7 said she found Resident #6 on the floor in her room by the bathroom door. CNA #7 called RN #7 to the room. RN # 7 asked if Resident #6 hit her head. CNA #7 stated " yes", because her head was against the wall. RN #7 said, "I don't have time for this, I'm not sending her out." CNA #7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 46	M 640		

and RN #7 assisted Resident #6 back in the wheelchair. Resident #6 continued to yell out in pain. Resident #6 was wheeled to the dayroom. CNA #7 said she checked on the resident all day. CNA #7 said she went back to RN #7 and asked if she would send Resident #6 out because she continues to complain of pain. RN #7 said she has had so many falls already, she doesn't have time to send her out. CNA #7 said after lunch Resident #6 vomited and complained of pain to her hip during Activities of Daily Living (ADL) care. CNA #7 told RN#7 and medication was administered for pain and nausea. CNA #7 also said RN #7 said the resident did not have any broken bones when she was sent out to the hospital. CNA #7 said when she found out Resident #6 had a right hip fracture, she knew she had to tell the truth. CNA #7 said she told CNA #8 and CNA # 9 about the situation. Both CNAs told her to write a statement and keep, just in case something happened. CNA #7 was suspended pending investigation. Both CNAs were interviewed and confirmed CNA #7 did talk to them about Resident #6 fall and RN #7 refusing to write an incident report or send Resident #6 to the hospital for an evaluation. Both CNA's advised CNA #7 to write a statement and to keep it. The Administrator said she interviewed LPN #2.LPN#2 said she received in report from RN #7 that Resident #6 was lowered to the floor. LPN #2 said she sent Resident #6 to the hospital because she continued to vomit and complain of back pain. The Administrator called an emergency Quality Assurance Performance Improvement (QAPI) meeting on 7/8/2021.

Record review of the facility's in-service dated 3/16/21 and 5/24/21 revealed Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 was educated on Abuse, Neglect,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 640	Continued From page 47 Misappropriation, and Exploitation.	M 640		