STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted seven (7) Complaint Investigations (CI MS #2638894, CI MS #2681269, CI MS #2664970, CI MS #2651812, CI MS #2648248, CI MS #2681255, and CI MS #2683513) at the facility from 12/01/25 to 12/04/25. CI MS #2638894 was investigated for Quality of Care/Treatment. CI MS #2664970 was investigated for Resident/Patient/Client Abuse, CI MS #2651812 was investigated for Resident/Patient/Client Abuse Misappropriation of Property, CI MS #2648248 was investigated for Quality of Care and Treatment, CI MS #2681269 was investigated for Resident/Patient/Client Abuse, and CI MS #2683513 was investigated for Resident/Patient/Client Abuse with no deficiencies cited. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid for CI MS #2681255 which was investigated for Accident Hazards and F689 was cited. On 11/28/25, at approximately 10:40 AM a member of the facility staff observed Resident #9 with a Rollator exiting the facility behind a visiting nurse. Resident # 9 was outside unsupervised for approximately 22 minutes. At 11:02 AM Resident # 9 was located 0.4 miles away from the facility down a busy four lane street in the parking lot of a local funeral home. The temperature at the time was 51 degrees; the resident was dressed in a sweatshirt and jeans. The facility's failure to provide adequate supervision to prevent the elopement of Resident #9 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/28/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of "J". The SA notified the facility's Administrator of the IJ and SQC on 12/2/25, at 3:20 PM and provided the	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 Administrator with the IJ template. Based on the facility's implementation of corrective actions on 11/29/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 11/30/25, prior to the SA's first entrance on 12/1/25. The facility held a license for 100 beds, with a census of 86.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of ten (10) sampled residents, Resident #9. On 11/28/25, at approximately 10:40 AM a member of the facility staff observed Resident #9 with a Rollator exit the facility behind a visiting nurse. Resident # 9 was outside unsupervised for approximately 22 minutes. At 11:02 AM Resident # 9 was located 0.4 miles away from the facility down a busy four lane street in the parking lot of a local funeral home. The temperature at the time was 51 degrees; the resident was dressed in a sweatshirt and jeans. The facility's failure to provide adequate supervision to prevent the elopement of Resident #9 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death.	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 2 The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/28/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of "J". The SA notified the facility's Administrator of the IJ and SQC on 12/2/25, at 3:20 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 11/29/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 11/30/25, prior to the SA's first entrance on 12/1/25. Findings include: Record review of facility “Elopement/Unsafe Wandering Plan” dated 02/07/2012 revealed, “Policy: It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life and safe environment procedures… Risk Evaluation: An evaluation of the resident's risk for unsafe wandering or elopement is to be conducted on admission, quarterly, after a significant change in condition, and after an incident of elopement. Identification: Residents at risk will have some type of “identifier” on their person… Plan of Care: If a resident is identified at risk for elopement or unsafe wandering, a preventative plan of care is to be implemented at the time the risk is identified. Unsafe wandering and/or elopement potential is to be entered into the ADL (activity of daily living) system and ADL plan of care. Supervision: Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary. Facility Systems: Systems such as alarms, Wanderguard systems and special locks/keypads as allowed by state and local authorities will be utilized to the extent possible…” Record review of the Admission Record for Resident #9 revealed the facility admitted the resident on 11/11/25 and the resident had diagnoses including Depression, Unspecified, Repeated Falls, and Chronic Atrial Fibrillation. Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 11/18/25 for Resident #9 revealed the resident had a Brief Interview	F0689		

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F0689 SS = SQC-J	Continued from page 3 for Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors. Record review of the clinical note dated 11/26/2025 revealed the entry was labeled as New Recommendations and directed the reader to review the clinical notes for details. The note identified a new referral for psychiatric symptom management and a psychiatric medication review. The documented reason for referral was listed as new referral, psychiatric symptom management, and psychiatric medication review. During an interview on 12/03/24 at 11:30 AM Licensed Nursing Home Administrator (LNHA) described her understanding of the incident involving Resident 9. She stated she first became aware of the elopement when therapy staff sent a message reporting that the resident had been seen walking out of the facility. She said this occurred at 9:55 AM. She stated that staff should have verified the resident's location immediately and initiated the missing resident procedure without delay. She stated Registered Nurse (RN) # 1 last saw the resident at 10:37 AM, but staff did not maintain awareness of the resident's movement near the exit. She said the therapist observed the resident exiting behind a hospice Certified Nurse Aide who held the door open. She stated that this indicated a failure to follow the facility's Wandering and Missing Resident Procedures because staff did not block the exit or redirect the resident. She stated that between 10:37 AM and 10:40 AM no staff intervened to stop the resident, and no one initiated the Elopement and Wandering Prevention Plan as required. She said this allowed Resident #9 to leave the building unsupervised. The LNHA stated that Resident # 9 was found at 11:02 AM off the premises on a nearby street. She said the resident was near the roadway area and appeared anxious. She said the resident told staff that someone was trying to kill her. She confirmed that the resident was returned to the facility at 11:09 AM. During an interview 12/03/25 at 1:25 PM, Physical Therapist Assistant (PTA) # 1 revealed he returned to the building through the south entrance at approximately 10:40 AM. He stated that when he opened the door to enter, Resident # 9 was standing at the door waiting to exit with a female nurse in blue scrubs. He stated he stepped to the side and held the door for them to exit because he assumed the nurse was accompanying the resident. He stated he observed both individuals from the therapy room. He reported that the nurse got into her vehicle and left the premises, and	F0689		

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F0689 SS = SQC-J	Continued from page 4 Resident # 9 continued walking toward the south parking lot entrance and exit. He stated Resident # 9 stood for a few minutes in an area where other residents who have the authority to sign themselves out commonly gather. He stated he believed she had possibly signed herself out. He stated that when he observed Resident # 9 completely exit the premises and take a right onto street in front of the facility, he decided to send a group text to inform his coworkers. He stated that once he learned this was an active elopement, he assisted the social worker, and the Administrator, in locating the resident. He stated they found the resident in a parking lot at a nearby Funeral Home. He stated they collectively calmed the resident, who expressed that someone was coming to the facility to kill her and her husband. He stated the resident agreed to return to the facility and rode back with the social worker and administrator. During an interview with the Social Worker # 1 on 12/03/25, at approximately 11:09 AM, the staff member stated the staffing coordinator contacted her to ask whether the resident was in their room. She reported that she immediately went to check and found that the resident was not present in the room. She stated a Code W was initiated throughout the building. She reported that shortly afterward, administration contacted her and informed her that the resident had left the facility following a visitor. She stated that a body audit was performed once the resident returned. She reported that vital signs were obtained and were within normal limits with no abnormalities noted at that time. She stated the resident was last visibly seen by her at 10:37 AM. She stated she provided this information to accurately document the events as she observed them. During an interview on 12/04/25 at 3:00 PM, Registered Nurse (RN) #1 stated that at approximately 11:09 AM on the day of the incident, the staffing coordinator contacted her and asked whether the resident was present in her room. She stated the coordinator told her therapy personnel had asked if the Resident # 9 was supposed to be on the highway. She stated she immediately went to check and found the resident was not in her room. She stated a Code W was initiated throughout the building. She stated that a few minutes later, administration and Social Services notified her that the resident had been observed standing in a parking lot down the road. She stated that when the resident returned to the facility, she assessed the resident for injuries and found none. She stated vital signs were taken and were within normal limits. She stated therapy personnel informed staff that he believed the resident was leaving with the lady in blue	F0689		

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F0689 SS = SQC-J	Continued from page 5 scrubs, and because of that assumption, he entered the exit code to allow them to leave the building. She stated the lady in blue scrubs was identified as a hospice nurse. She stated the hospice nurse was contacted and reported that the tall man in therapy had let both of them out but clarified that the resident was not with her. She stated Social Services contacted the resident's responsible party, who arrived at the facility to meet with the resident. She stated administration interviewed the resident, and the resident reported that her husband told her someone was going to kill him, and she believed she needed to leave the facility to avoid being harmed. She stated the resident was assured by administration that safety was being provided for both her and her spouse, and the resident voiced understanding. She stated the on-call nurse practitioner was contacted and provided a new order for a psychiatric evaluation. On 12/03/25 at 10:00 AM observation revealed the first parking space on the right was approximately fifty-five feet from the front entrance. Observation revealedsix other vehicles traveling through the parking lot. The driveway which led from the facility's front area, along the front of the parking spaces led to a busy four lane street with a speed limit of thirty-five miles per hour and no cross walks; observation revealed one hundred twenty-five (125) vehicles traveling on the boulevard between 10:00 AM and 10:05 AM. Record review of the local weather history according to WWW.Wunderground, Copyright The Weather Channel, for the facility for 10:53 AM on 11/28/25 revealed the temperature was fifty-one (51) degrees Fahrenheit, with zero (0) precipitation, five (5) mile per hour winds. Corrective Action Plan On 12/2/25 at 3:20 PM, the State Agency presented an Immediate Jeopardy templet which notified the Administrator of the facility that the facility failed to ensure Resident #9, who has a Brief Interview for Mental Status (BIMS) score of 9 (cognitively impaired) was adequately supervised to prevent elopement. On 11/28/25 at approximately 10:30 AM, Resident #9 was witnessed leaving the facility behind another staff member and was located at a busy intersection approx. 0.4 miles from the facility. Staff did not prevent the resident from leaving, did not verify her location, and did not intervene as required by the facility's elopement and wandering procedures. This placed resident #9 and other residents at risk for elopement in a situation that was likely to cause serious injury, serious harm, impairment or death.	F0689		

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F0689 SS = SQC-J	Continued from page 6 On 11/28/2025, at 10:55 am, Physical Therapy Assistant (PTA), sent a message to the Interdisciplinary Team (IDT) group message thread asking if Resident #9 was supposed to be walking on the highway. At this time, the IDT initiated a search within the building and outside the parameters for Resident #9. The Administrator immediately went to check Resident #9's room; Resident #9 was not in there. The Administrator then proceeded to the front entrance to see if she could see Resident #9; she could not. Social Service Director (SSD) and the PTA came outside to look as well. At 11:00 am the PTA, SSD and the Administrator got in vehicles to go look for Resident #9. At 11:02 am we located Resident #9 in front of the funeral home, 0.4 miles from the facility. Resident #9 was found safe and uninjured. The temperature was in the upper 50s. Resident #9 was appropriately dressed in a sweatshirt and jeans. Corrective Action: On 11/28/25 at 10:00 AM, Resident #9 was last seen by Certified Nursing Assistant (CNA) #1. On 11/28/25 at 10:37 AM, Resident #9 was last seen by Registered Nurse (RN) #1. On 11/28/25 at 11:05 AM, SSD called Resident #9s Resident Representative (RR), RR did not answer. On 11/28/25 at 11:18 AM, Resident #9s RR returned the call to SSD where she was informed of the incident. On 11/28/25 at 11:18 AM, a census was printed for the North and South unit, and a head count was completed to ensure all residents in the facility were accounted for. On 11/28/25 at 11:38 AM, a body audit was completed on Resident #9 by RN with no injuries noted. On 11/28/25 at 12:19 PM, Administrator reported the incident to the State Agency.	F0689		

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F0689 SS = SQC-J	Continued from page 7 On 11/28/25 at 12:26 PM, Maintenance #1 completed an audit on all doors and windows to ensure proper functioning. On 11/28/25 at 12:28 PM, On-Call Nurse Practitioner (NP) #1 was notified by RN. A new order for an in-house psych eval was given. On 11/28/25 at 12:30 PM, Medical Director, Medical Doctor (MD) and NP #2 were notified by Administrator of the incident. On 11/28/25 at 1:00 PM, All staff in-services began on “Elopement/Unsafe wandering plan” and the “Emergency Procedure – Missing Resident and Abuse and Neglect. All in-services were completed on 11/29/25 by Assistant Director of Nursing (ADON). On 11/28/25 at 1:30 PM, An Elopement Drill was conducted by Maintenance Director and completed on 11/29/25. On 11/28/25 at 2:00 PM, An emergency Quality Assurance Performance Improvement (QAPI) meeting was held by Administrator with IDT members to discuss the incident, actions to be taken and further interventions put in place. The QAPI committee reviewed the incident and actions taken. The policy was reviewed with no recommendations for change. All protocols were followed per policy; no changes were needed. The QAPI committee determined at this time to prevent further adverse events the interventions would include adding Resident #9 to the wander book and providing a wander guard. Person centered in-services will be completed with staff whenever any new residents are identified as an elopement risk and any newly identified residents who are at risk for elopement. An elopement drill on all shifts and one elopement drill per week on alternating shifts for four weeks. These interventions are as follows: Head count by census, Maintenance quality check on all doors and windows, an elopement drill for all staff on each shift, then weekly for 4 weeks on alternating shifts, Then monthly three (3) months (Elopement/Unsafe Wandering Missing Resident, February 2010, Elopement Prevention Plan – Process. Upon hire and annually, the procedure is to notify all personnel on duty of the resident's absence, call a code “W” for missing resident with resident’s name, search the premises inside and out, alert RR, MD, police if	F0689		

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F0689 SS = SQC-J	Continued from page 8 needed, regional director and state agency). SSD will complete 100% audits on all wanderers, update wander book, update care plans, in-service on wander book location, conduct interview with resident for any psychosocial harm. On 11/28/25 at 2:00 PM, Medication Administration Record (MAR) was updated with hourly visual monitoring for Nursing by RN. Point of Care (POC) updated for hourly visual tasks to fire off for CNAs to mark complete by Minimum Data Set (MDS) Nurse. On 11/28/25 at 2:30 PM, SSD conducted an interview with the resident to assess psychosocial harm. No psychosocial harm was noted. On 11/28/25 at 3:00 PM, Wander Guard bracelet was placed on Resident #9's left wrist. On 11/28/25 at 3:30 PM, Care plans were updated by SSD. On 11/28/25 at 4:00 PM a 100% audit was done on all wanderers by SSD and Wander Book was 100% updated with photos and face sheets. On 11/28/25 at 4:30 pm a 100% audit was done by SSD on all Wander Guard bracelets to ensure appropriate functional ability. The root cause analysis determined by the administrator and Director of Nursing found that the PTA assumed that CNA #2 was one of the facility staff members and that Resident #9 was being supervised by CNA #2. It was determined through an interview with the PTA that he was unsure if Resident #9 was her own Resident Representative (RR) and had signed herself out. It was determined through an interview with CNA #2 that she was unaware that Resident #9 was a resident. Resident #9 had two bags packed and looked as if she was visiting a family member. On 12/2/25 at 4:53 PM, Incident was reported to the Attorney General's Office by Administrator. On 11/28/25 The Maintenance Director Performed elopement drills on all shifts, this will continue for four (4) weeks and monthly for three (3) months and	F0689		

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F0689 SS = SQC-J	Continued from page 9 brought before the QAPI committee each month for review and recommendations. Any issues will be addressed immediately by the Administrator and the DON. Facility alleges that all corrective actions were complete on 11/29/25 and Immediate Jeopardy removed on 11/30/25. On 12/04/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 11/30/25, prior to the SA entrance on 12/1/25.	F0689		