STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD , PASCAGOULA, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #2736288) at the facility on 03/26/2026. CI MS #2736288 was investigated for quality of care and treatment and nursing services. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656. The facility held a license for 100 beds, with a census of 86.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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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F0656 SS = D	Continued from page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop the comprehensive person-centered care plan for pressure injuries for one (1) of three (3) sampled residents. (Resident #1). Findings include: A review of the facility's "Care Plan Policy and Procedure", undated, revealed, "Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches. Procedure...2. A Comprehensive Person-Centered Care Plan will be completed...as needed..." Record Review of the “Admission Record” revealed Resident #1 was admitted by the facility on 11/18/25 with the diagnoses including Type 2 Diabetes Mellitus with ketoacidosis without coma. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26, revealed Resident #1 had a Brief Interview for Mental Status Score (BIMS) of 12, which indicated her cognition was moderately impaired. Review of Section M revealed two (2) unstageable pressure injuries presenting as deep tissue injury (DTI).	F0656		

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F0656 SS = D	Continued from page 2 A record review of Resident's #1 "Order Summary Report" revealed physician orders dated 12/10/25 for treatment to right and left DTI pressure ulcers. A record review of resident's #1, Comprehensive Care Plan revealed there was no care plan developed to reflect the DTIs on the Left and Right heels, which was inconsistent with the physician orders. On 3/26/26 at 1:30 PM, during an interview with Licensed Practical Nurse (LPN) #1 and LPN #2 Care Plan Nurse, they explained they are responsible for completion of the MDS and Care Plan (CP). LPN #2 stated that the CP is developed based on the MDS and the physician orders. LPN #1 reviewed Resident's #1's CP and confirmed there was not a CP developed related to the DTIs on the left and right heels. She reported that the wound care nurse was responsible for completing wound care orders and updates in the CP. LPN #2 stated that they audit by comparing orders to the CP periodically and it must have been missed. On 3/26/26 at 2:30 PM, during an interview with Director of Nursing (DON), she stated her expectation is for the wound care nurse to update the care plan with new orders for wound care treatments. ON 3/26/26 at 2:37 PM, during an interview with Registered Nurse (RN) #1, she explained she is able to update care plan interventions, but she had not been trained on developing a new focused care plan. She said, she had not developed or added the physician orders for Resident #1's DTIs to her left and right heels on the care plan and was not aware that it was her responsibility to do so.	F0656		