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	255112	A. BUILDING _____ B. WING _____	04/06/2023

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PLEASANT HILLS COM LIV CENTER	1600 RAYMOND RD JACKSON, MS 39204

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 4/4/23 through 4/6/23. During the survey, the SA determined that the facility was not in compliance with the requirements for partipation in Medicare and Medicaid and cited F-656, F-677, F-688, F-695, F-761, F-806, and F-865. The census at the time of the survey was 70 and the facility is licensed for 120.	F 000		
F 656 SS=E	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	F 656		5/17/23

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

Electronically Signed | 04/26/2023

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (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 observation, interviews, record reviews, and facility policy review, the facility failed to implement the Comprehensive Care Plan for two (2) residents needing nail care and develop a Care Plan for a resident needing a hand roll. This concern was identified for three (3) of 22 resident care plans reviewed. Residents #20, #27, and #39 Findings include: Review of the facility policy titled, "Care Plan - Comprehensive," undated, " ...It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs ..."	F 656	-The care plan for Resident # 39 was revised on 4/6/23 to include rolled towels to bilateral hands by the Minimum Data Set (MDS) Nurse. The Registered Nurse (RN) Supervisor placed rolled towels in Resident # 39's hands on 4/6/23. The Assistant Director of Nursing (ADON) provided nail care for Resident # 20 and Resident # 27 on 4/6/23. -All residents have the potential to be affected. -The ADON observed all residents for nail care and splinting devices on 4/6/23 with no negative findings noted. The DON reviewed all resident orders on 4/20/23 to ensure all splinting devices were care planned. The Director of Nursing (DON)	

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F 656	Continued From page 2 Resident #20 An observation on 4/4/23 at 08:33 AM, revealed Resident #20 had a brown substance underneath all her fingernails, that were also noted to be long with chipped fingernail polish. An observation and interview on 4/5/23 at 8:33 AM, with Certified Nurse Assistant (CNA) #1, confirmed that Resident #20's fingernails had a brown substance underneath all her fingernails. She revealed it is the CNA's responsibility to provide nail care for the residents and clean them with daily Activities of Daily Living (ADLs) and baths. Record review of Resident #20's current Care Plan, initiated 5/28/20, revealed Resident #20 is at risk for an ADL self-care performance deficit related to diagnosis of Parkinson's and Dementia with a goal of maintaining the current level of function and showing improvement through the review date. Interventions included checking nail length and trimming and cleaning them on bath day and as necessary, with reporting any changes to the nurse. Record review of Resident #20's "Admission Record," revealed the facility admitted the resident to the facility on 5/19/20. Resident #20's medical diagnoses included Parkinson's Disease and Dementia. Record review of Resident #20's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/10/23, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident	F 656	in-serviced all nursing staff on 4/19/23 regarding the implementation of care plans including nail care and splinting devices. The DON in-serviced the MDS staff regarding developing comprehensive care plans on 4/19/23. -The DON will audit 5 (five) resident care plans weekly to ensure care plans are complete and accurate beginning 4/21/23 then monthly beginning on 5/19/23 and ending on 7/19/23, document findings and take corrective action as needed. The ADON will make rounds weekly to observe the implementation of care plans including hand rolls and nail care beginning 4/21/23 then monthly beginning on 5/19/23 and ending on 7/19/23, document findings and take corrective action as needed. The DON will report findings from weekly care plan audits then monthly care plan audits to the Quality Assessment and Performance Improvement Committee at the monthly meetings beginning on 5/16/23 and ending on 7/25/23 for review, revision and/or resolution of the plan as needed. The ADON will report findings from weekly nail care rounds then monthly nail care rounds to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning on 5/16/23 and ending on 7/25/23 for review, revision and/or resolution of the plan as needed.	

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F 656	Continued From page 3	F 656		

was severely cognitively impaired and in Section G, personal hygiene, the resident needed extensive assistance.

Resident #27

An observation on 4/4/23 at 10:15 AM, revealed Resident #27 had a brown substance underneath her long-jagged fingernails.

An observation and interview on 4/5/23 at 8:40 AM, with CNA #2 confirmed that Resident #27 had three fingernails with a brown substance underneath and several long-jagged nails. CNA #2 confirmed that the CNA's are responsible for both cleaning and trimming of this resident's nails with her baths and it should have been done.

Record review of Resident #27's Care Plan, initiated 3/22/16, revealed the resident had an ADL self-care performance deficit related to Cerebral Vascular Accident (CVA) and diagnosis of right sided hemiplegia and required staff assistance with ADLS's, with a goal to be clean, well-groomed, and odor free. Interventions included checking nail length and trimming and cleaning them on bath day and as necessary, with reporting any changes to the nurse.

Record review of Resident #27's "Admission Record" revealed, the facility admitted the resident to the facility on 5/17/22. Resident' #27's diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side.

Record review of Resident #27's Quarterly Minimum Data Set with an Assessment Reference Date of 1/12/23, revealed in Section C,

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F 656	Continued From page 4	F 656		

a Brief Interview for Mental Status (BIMS) score of 99, which indicates the resident is severely cognitively impaired and in Section G, that the resident is totally dependent with personal hygiene.

Resident #39

Record review of the "Order Summary Report" with "Active Orders as of: 4/5/2023", revealed Resident #39 had a Physicians Orders, dated 9/30/22, for, "Place rolled towels to bilateral hands daily ..."
An observation on 4/4/23 at 9:45 AM and 11:45 AM, revealed Resident #39 lying in bed with his hands drawn. There were no hand rolls in place.

An interview with Licensed Practical Nurse (LPN) #1, on 4/5/23 at 10:07 AM, revealed that Resident #39 was supposed to have hand towels placed in his hands.

Record review of the "Admission Record" revealed the facility admitted Resident #39 on 2/15/19 and he had diagnoses that included Dementia, Muscle Wasting and Atrophy, and Contracture.

Record review revealed a Brief Interview for Mental Status (BIMS) Staff Interview-V2 dated 1/23/23, revealed Resident #39 had a memory problem and was moderately impaired regarding cognitive skills for daily decision making.

An interview with LPN #4 on 4/5/23 at 5:40 PM, revealed she was the MDS coordinator. She confirmed that Resident #39 had a physician's order for hand rolls and is not sure why the care plan got missed. She confirmed Resident #39

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F 656	Continued From page 5 should have had a care plan put in place. An interview on 4/6/23 at 10:05 AM, with Licensed Practical Nurse (LPN) #5, revealed that if the resident had a diagnosis, then there should be a care plan to go with it and it should be used. An interview of 4/6/23 at 4:00 PM, with Social Services #1 revealed the purpose of care plans is to be a guide for the staff to provide care to the residents and to know what to do if something different comes up. An interview on 4/6/23 at 4:10 PM, with the Director of Nurses (DON), revealed the purpose of the care plan was to give the staff an idea of how to appropriately care for the resident. She confirmed that Resident #39 does not have a care plan in place for contractures or hand rolls and agreed that this should have been done for staff to be aware of how to care for the contractures.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review the facility failed to provide Activities of Daily Living (ADL's) for a resident that was dependent on staff as evidenced by long fingernails with a brown substance under the nails for two (2) of 70 residents reviewed for ADL's. Resident #20 &	F 677	-The Assistant Director of Nursing (ADON) provided nail care for Resident # 20 and Resident # 27 on 4/6/23. -All residents that require assistance with activities of daily living (ADL) have the potential to be affected. -The ADON observed all residents for nail	5/17/23

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F 677	Continued From page 6 #27. Findings include: Record review of the facility policy titled, "Nails, Care of (Finger and Toe)" dated 7/15/03, revealed ... "Purpose 1. To provide cleanliness 2. To prevent the spread of infection ..." Resident #20 On 4/4/23 at 8:33 AM, observation revealed Resident #20 had a brown substance underneath all her fingernails, that were also noted to be long with chipped fingernail polish. During an observation and interview on 4/5/23 at 8:33 AM, with Certified Nurse Assistant (CNA) #1, confirmed that Resident #20's fingernails had a brown substance under all her nails and stated, "Oh yes, they need cleaning." She revealed it is the CNA's responsibility to provide nail care for the residents and clean them with daily ADL's and baths. Record review of Resident #20's "Admission Record," revealed the facility admitted the resident to the facility on 5/19/20. Resident #20's medical diagnoses included Parkinson's Disease and Dementia. Record review of Resident #20's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/10/23, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident was severely cognitively impaired and in Section G, that the Activities of Daily Living (ADL) for bathing did not occur and with personal hygiene,	F 677	care on 4/6/23 with no negative findings noted. The Director of Nursing (DON) in-serviced all nursing staff on 4/19/23 regarding ADL care including nail care. -The ADON will make rounds weekly to observe all residents for nail care beginning 4/21/23 then monthly beginning on 5/19/23 and ending on 7/19/23, document findings and take corrective action as needed. The ADON will report findings from weekly nail care rounds then monthly nail care rounds to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning on 5/16/23 and ending on 7/25/23 for review, revision and/or resolution of the plan as needed.	

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F 677	Continued From page 7	F 677		

the resident needed extensive assistance. Record review of Resident #20's MDS with an ARD of 10/12/22, revealed in Section G, that the resident was totally dependent for bathing.

Resident #27

On 4/4/23 at 10:15 AM, an observation revealed Resident #27 with a brown substance underneath her long-jagged fingernails.

On 4/5/23 at 8:40 AM, during an observation and interview with CNA #2 confirmed that Resident #27 had three fingernails with a brown substance underneath and several long-jagged nails. She confirmed that the CNA's are responsible for both cleaning and trimming of this resident's nails with her baths and it should have been done.

On 4/5/23 at 8:45 AM, in an interview with Licensed Practical Nurse (LPN) #7 confirmed that it is the responsibility of the CNAs to provide Resident #27's nail care.

Record review of Resident #27's "Admission Record" revealed, the facility admitted the resident to the facility on 5/17/22. Resident' #27's diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side.

Record review of Resident #27's Quarterly Minimum Data Set with an Assessment Reference Date of 1/12/23, revealed in Section C, a Brief Interview for Mental Status of 99, which indicates the resident is severely cognitively impaired and in Section G, that the resident is totally dependent.

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F 677	Continued From page 8 An interview on 4/5/23 at 10:00 AM, with the Director of Nurses (DON) confirmed that the CNA's and the nurses are responsible for nail care. She confirmed that CNA's can clean and trim or file any resident's nails, but if they are diabetic then the nurse would be responsible for trimming their nails. She revealed that the reason a resident's nails need to be cleaned was to prevent an infection and trimming of the nails is to prevent any skin issues from occurring from the long nails.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide appropriate treatment and services to prevent the possible decrease in Range of Motion (ROM) for	F 688	-The care plan for Resident # 39 was revised on 4/6/23 to include rolled towels to bilateral hands by the Minimum Data Set (MDS) Nurse. The Registered Nurse	5/17/23

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F 688	Continued From page 9 one (1) of 22 residents reviewed. Resident #39 Findings include: The facility Administrator (ADM) provided documentation on the facility's letterhead that revealed the facility did not have a policy related to splints and/or hand rolls. Two observations, on 04/04/23 at 09:45 AM and 11:45 AM, revealed Resident #39 lying in bed with his hands drawn. There were no hand rolls in place. Observations on 4/05/23 at 08:15 AM and 10:00 AM, revealed Resident #39 lying in bed, hands drawn, and there were no hand rolls in place. Record review of the "Order Summary Report" with "Active Orders As Of: 04/05/2023", revealed Resident #39 had a physicians order, dated 9/30/22, for, "Place rolled towels to bilateral hands daily ..." An interview with Licensed Practical Nurse (LPN) #1, on 4/05/23 at 10:07 AM, revealed that Resident #39 was supposed to have hand towels placed in his hands. She stated that he did not have them in place when she went to his room this morning (4/5/23). She stated the hand rolls should only be removed when Resident #39 needed his hands to be washed and dried. An interview and observation on 4/05/23 at 10:15 AM, with Registered Nurse (RN) #1, revealed Resident #39 lying was lying in bed without hand rolls. She confirmed that Resident #39 had a Physician's order for hand rolls daily and that the aides or the nurses could apply them.	F 688	(RN) Supervisor placed rolled towels in Resident # 39□s hands on 4/6/23. Resident #39 was assessed by the Director of Nursing (DON) and Occupational Therapist on 4/17/23 and no negative outcome in Range of Motion (ROM) was noted. -All residents with splinting devices ordered have the potential to be affected. -The Assistant Director of Nursing (ADON) observed all residents for splinting devices as ordered on 4/6/23 with no negative findings noted. The Director of Nursing (DON) reviewed all resident orders on 4/20/23 to ensure all splinting devices were care planned. The Director of Nursing (DON) in-serviced all nursing staff on 4/19/23 regarding splinting devices. -The ADON will make rounds weekly to observe splinting devices including hand rolls as ordered beginning 4/21/23 then monthly beginning on 5/19/23 and ending on 7/19/23, document findings and take corrective action as needed. The ADON will report findings from weekly rounds for observation of splinting devices then monthly rounds for observation of splinting devices to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning on 5/16/23 and ending on 7/25/23 for review, revision and/or resolution of the plan as needed.	

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F 688	Continued From page 10 An observation and Interview with the Director of Nursing (DON), on 4/05/23 at 10:25 AM, confirmed that Resident #39 did not have any hand rolls in place. She confirmed that not having hand rolls in place could cause his hand contractures to worsen. Record review of the "Admission Record" revealed the facility admitted Resident #39 on 2/15/19 with diagnoses that included Dementia, Muscle Wasting and Atrophy, and Contracture. Record review of the BIMS (Brief Interview for Mental Status) Staff Interview dated 1/23/23, revealed Resident #39 had a memory problem and was moderately impaired regarding cognitive skills for daily decision making.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to properly store oxygen tubing, nebulizer machine, nebulizer tubing, and nebulizer mask and failed to post cautionary and safety signs indicating the use of oxygen for one	F 695	-The Director of Nursing (DON) removed the nebulizer from the floor, changed the nebulizer and oxygen tubing, dated and placed tubing in a bag and placed an oxygen sign on the door for Resident # 21 on 4/5/23.	5/17/23

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F 695	Continued From page 11 (1) of seven (7) residents observed for oxygen therapy. Resident #21 Findings include: Record review of facility policy titled "Medications, Nebulizer (Handheld)", dated 8/25/14, revealed " ...The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. ... 27. Rinse and disinfect the nebulizer equipment according to facility protocol. ... 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 30. Change equipment and tubing every seven days, or according to facility protocol ..." Record review of facility policy titled, "Oxygen Use", dated 6/6/13, revealed " ...Purpose: To promote resident safety in administering oxygen... 2. The tubing should be kept off the floor". Record review of facility note on letterhead revealed, the facility "does not have a policy related to dating oxygen tubing or signs on resident room doors when oxygen is in use". An observation and interview on 4/4/23 at 8:45 AM, revealed Resident #21 on oxygen by way of oxygen concentrator and nasal cannula. The oxygen was not being used by the resident during this observation. The nebulizer machine was laying on the floor next to the resident's bed. The tubing for the oxygen as well as the tubing and mask for the nebulizer were laying in the resident's bed. There was no date on the oxygen tubing or on the humidification water bottle. There was no storage bag at the bedside. There was no signage posted to notify residents, staff, or	F 695	-All residents receiving respiratory care have the potential to be affected. -The DON made rounds, changed/dated oxygen and nebulizer tubing, ensured nebulizers were properly stored and oxygen signs were in place for all residents receiving oxygen and/or nebulizer treatments on 4/6/23. The DON in-serviced all nursing staff regarding storage of nebulizers and tubing, changing/dating tubing weekly and oxygen signage on 4/19/23. -The wound care nurse will make rounds to observe for proper storage of nebulizers and tubing, labeling of tubing and oxygen signage for all residents receiving respiratory care weekly beginning 4/21/23 then monthly beginning 5/19/23 and ending 7/25/23, document findings and take corrective action as needed. The wound care nurse will report findings from weekly then monthly rounds to observe proper storage of nebulizers and tubing, labeling of tubing and oxygen signage to the Quality Assurance and Performance Improvement (QAPI) Committee at the monthly meetings beginning on 5/16/23 and ending on 7/25/23 for review, revision and/or resolution of the plan as needed.	

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F 695	Continued From page 12	F 695		

visitors of oxygen in use. The resident stated he used his oxygen when needed, but he currently does not require it. He also stated he received nebulizer treatments for his breathing. The resident stated he did not have a bag for the storage of the tubing.

An observation and interview with the Director of Nursing (DON) on 4/5/23 at 5:15 PM, revealed the oxygen and nebulizer tubing were not stored properly. The nebulizer remained on the floor with the nebulizer tubing detached from the nebulizer and that end of tubing was laying on the floor. The resident was using oxygen and the nebulizer tubing and mask were laying in the resident's bed. The oxygen tubing, humidification water bottle, and nebulizer tubing were not dated. There was no oxygen signage on the door. The DON confirmed the respiratory care items were not labeled or stored properly and this could cause an infection. She confirmed there was no signage on the resident's door that would alert staff, residents, or visitors that oxygen was being used in the room and this was needed for safety.

During an interview on 4/6/23 at 12:45 PM, the Administrator confirmed he was informed yesterday that the nebulizer was on the floor, no date on the tubing and water bottle, and no signage for oxygen in use and this could be a safety and an infection control concern.

Record review of Resident #21's Order Summary Report revealed physician orders dated 1/27/23 for "Oxygen at 2 liters per minute via nasal cannula ... Ipratropium-Albuterol Solution ...3 ml (milliliters) to inhale orally ...Pulmicort Inhalation Suspension 0.25mg(milligrams)/2ml...1 vial inhale orally ...Proventil Inhalation Aerosol Solution ...

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F 695	Continued From page 13 0.5 ml to inhale orally ...Brovana Inhalation Nebulization Solution ...2 ml inhale orally ..." Record review of the "Admission Record" revealed the facility admitted Resident #21 on 12/14/22 with diagnoses that included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Emphysema. Record review of Minimum Data Set (MDS) with Assessment Reference Date of 2/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was moderately impaired cognitively.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/17/23

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F 761	Continued From page 14 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure medications were under the direct observation of the person administering the medication for one (1) of three (3) survey days. Resident #175 Findings included: Record review of facility policy titled, "Medication Administration - General Guidelines", dated 8/25/14 revealed, " ...Medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so ...Procedure ...2. Administration ... b. Medications are administered in accordance with written orders of the attending physician... d. Medications are administered at the time prepared. Medications are not pre-poured. e. Medications are administered without unnecessary interruptions. f. The person who prepares the dose for administration is the person who administers the dose ...j. Medications are administered with 60 minutes of schedule time, except before or after meal order, which are administered based on mealtimes ..." Record review of facility policy titled, "Medications, Individual Medication Storage Cabinets", dated 8/25/14, revealed, " ...Process ...4. Medication will be prepared, administered, and documented according to policy governing	F 761	-Licensed Practical Nurse #2 removed the medication from Resident #175's bedside on 4/4/23. The Director of Nursing (DON) contacted the physician on 4/4/23 to notify of the medication administered late for Resident # 175. -All residents have the potential to be affected. -The DON made rounds throughout the facility on 4/6/23 to observe proper storage of medications with no negative findings noted. The DON in-serviced all nurses regarding storage of medication, medication administration and notifying physician of late medications on 4/19/23. -The Staff Development (SD) Nurse will perform weekly med pass audits of 1 (one) nurse on each shift to observe proper medication administration and storage beginning 4/21/23 and ongoing, document findings and take corrective action as needed. The Pharmacy Consultant will perform monthly med pass audits beginning 4/12/23 and ongoing, document and report findings to the DON. The SD Nurse will report findings from weekly med pass audits to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning 5/16/23 and ongoing for review, revision and/or resolution of the plan as needed. The DON will report findings from monthly	

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F 761	Continued From page 15 medication administration". During an observation and interview with Licensed Practical Nurse (LPN) #2, on 4/4/23 at 8:20 AM, revealed in Resident #175's room, two plastic medication cups stacked inside each other were on the overbed table. The medication cup on the bottom was noted to have multiple medications and the medication cup on the top had one medication. The resident was awake and lying in his bed. LPN #2 entered the room and stated she was the nurse for Resident #175. LPN #2 explained the single medication in the top cup was pain medication the resident had requested. She stated the medications in the bottom cup were medications that were scheduled to be given at 6:00 AM, but the resident did not want to take these until breakfast, so the night nurse, LPN #3, placed these in the medication cart and asked LPN #2 to give them with breakfast. She stated the medications were Renvela, Calcium Acetate (2 capsules), Pantoprazole, Levothyroxine, and Hydralazine. She stated the single pain medication was Percocet. An interview with LPN #2 on 4/4/23 at 9:30 AM, revealed the night shift nurse took the medications out of the packages and placed them in the medication cup and when she attempted to give the meds, the resident requested to wait until he had breakfast to prevent nausea. She revealed the night nurse stored these in the med cart and asked her to give them with his breakfast. She stated she threw those medications away and she checked the order and pulled the 6:00 AM medications as well as the pain medication requested by the resident. She placed the medications on the overbed table since the resident asked her to give him a minute	F 761	med pass audits performed by the Pharmacy Consultant to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning 5/16/23 and ongoing for review, revision and/or resolution of the plan as needed.	

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F 761	Continued From page 16	F 761		

to sit up. She stated the breakfast trays were arriving, so she took the medication cart back to the nurse's station and signed out the pain medication. She stated she was only away from his bedside for a couple of minutes and the resident was in the room by himself, and no one entered his room during that time. She stated Resident #175's room was next to the nurse's station and was visible. She confirmed the medications should not have been left unattended and she should have watched Resident #175 take his medications as she usually did. She confirmed the doctor should be notified when medications were late. She stated she had received an in-service regarding medication administration.

An interview with the Director of Nursing on 4/5/23 at 4:45 PM, revealed the medications should not be left at a resident's bedside unless the evaluation for self-administering was done and Resident #175 had not been evaluated for this. She confirmed the facility failed to properly administer medications to the resident by leaving the medications unattended at bedside and administering late. She stated that by leaving the medications unattended, "anything could happen, or nothing could happen. We just do not know". She stated a roommate or a resident walking in the hall could go in and take the medications and have a dangerous reaction from them. She verified that to prevent a possible negative outcome, the nurse should remain with the medications until they are administered. She also confirmed if the meds were for 6 AM and given at 8:30 AM, they were administered late since they have an hour before and an hour after medication's scheduled time to administer and the physician was not notified.

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A phone interview with LPN #3 on 4/6/23 at 12:30 PM, revealed she was working Tuesday morning and Resident #175 was scheduled for 6:00 AM meds and he wanted to take these with breakfast. She stated she told the oncoming nurse that she did not give these because he wanted to take with breakfast and the meds were locked in the cart.

An interview with the Administrator on 4/6/23 at 12:15 PM, revealed he was not aware of the medications being left at the bedside of the resident. He stated he was not a clinician and could not make the decision on whether a resident was cognitively able to administer their own medications if they were left at the bedside, but the staff should follow the policy and physician's orders to prevent a possible problem when administering medications. He confirmed the facility failed to do this.

Record review of the "Order Summary Report" with "Active Orders As Of: 04/05/2023", revealed Resident #175 had Physician's Orders for, "Calcium Acetate ...Give 2 capsule by mouth three times a day", "Hydralazine HCl ...Give 2 tablet by mouth every 8 hours", "Levothyroxine Sodium ...Give 1 tablet by mouth one time day ...", Oxycodone ...Give 1 tablet by mouth every 6 hours as needed for Pain", "Pantoprazole Sodium ...Give 1 tablet by mouth one time a day ...", and "Renvela ...Give 1 tablet by mouth with meals ..."

Record review of electronic Medication Administration Record (eMAR), dated 4/1/2023 through 4/30/2023, revealed Levothyroxine, Pantoprazole, Hydralazine Hcl, and Renvela were scheduled to be administered at 6:00 AM. Calcium Acetate was scheduled to be

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F 761	Continued From page 18 administered at 6:30 AM. Record review of the "Admission Record" revealed the facility admitted Resident #175 on 3/10/23 with a diagnosis of Cellulitis of Left Upper Limb. Record review of the Brief Interview for Mental Status (BIMS) Interview, dated 4/3/23, revealed Resident #175 had a score of 15, which indicated he was cognitively intact.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to honor a resident's request for warming/re-warming his food and failed to honor a food preference for two (2) of 22 residents sampled. Resident # 175 and Resident #66 Findings included: Record review of facility policy titled, "Resident Rights" dated 11/23/16, revealed " ...It is the	F 806	-The Dietary Manager (DM) met with Resident # 175 and updated preferences on 4/10/23. The DM updated the tray ticket system for Resident # 66 to reflect food preferences on 4/6/23. -All residents have the potential to be affected. -The dietary department will re-warm residents food that has not been touched during dietary hours if food has been touched dietary will provide a new meal tray. Nursing staff will warm residents	5/17/23

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F 806	Continued From page 19 policy of this facility to promote and protect the rights of residents residing in this facility. 1. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 2. This facility will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness, and dignity. 3. The facility will make every effort to provide residents with a homelike environment based on his/her preferences, age, etc ..." Record review of facility's policy titled, " ...Resident Rights", revised and implemented on 11/28/16, revealed, " ...(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life ...The facility must protect and promote the rights of the resident ...(11)(ii)(L)(2)...When preparing the foods and meals, a facility must take into consideration residents' needs and preferences..." Record review of a document on facility letterhead, dated 4/6/23, and signed by the Administrator revealed, "The facility does not have a policy for nursing staff reheating the resident's food." Resident #175 During an interview on 4/4/23 at 8:20 AM, Resident #175 revealed that at times his food was cold, and the staff would not warm it up and they would also not warm up his canned food items. He stated that he needed to eat so his hand could heal, and he could regain his strength, but he was unable to eat cold food. He	F 806	food that is brought in after dietary hours. The DM interviewed all residents on 4/10/23 regarding food preferences and revised tray tickets as necessary. The Director of Nursing in-serviced all nursing staff regarding resident preferences including warming food on 4/19/23. The DM in-serviced all dietary staff regarding food preferences on 4/26/23. -The Social Worker will interview 5 (five) residents weekly regarding food preference and re-warming of food, notify DM of any changes, take corrective action as needed and document findings beginning 4/26/23 then monthly beginning 5/19/23 and ending 7/25/23. The Social Worker will report findings from weekly then monthly resident interviews regarding food preferences and re-warming of food to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meetings beginning 5/16/23 and ending 7/25/23 for review, revision and/or resolution of the plan as needed.	

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stated that the food usually arrived in his room warm, but if he was not ready to eat when the food arrived, it got cold and needed to be reheated. He also stated that he was "not in prison" and that this was a "nursing home" and "this is my home", so he should be able to have his food warmed so he could enjoy it. The resident stated he should have the choice to wait until he was ready to eat and to still have warm food. There had been times he asked the staff to heat some of his canned pasta he kept in his room so he could eat those for a meal or a snack, but the facility staff have refused to warm it for him.

An observation on 4/4/23 at 8:20 AM, revealed that Resident #175 lifted the lid of his breakfast tray and asked Licensed Practical Nurse (LPN) #2, who had come into the resident's room, if she could warm his breakfast. She informed the resident that the Director of Nursing (DON) had instructed the staff not to heat up food for the residents, so she could not heat it for him.

During an interview on 4/4/23 at 8:22 AM, LPN #2 stated the staff had been instructed by the DON to not heat up the residents' food, so she was unable to warm it up for him. She stated even though he wanted his food warmed, she was unable to do it. She stated a microwave was available, but they were unable to use it for residents' food.

During an interview on 4/5/23 at 4:30 PM, the DON revealed she did instruct the staff not to warm the resident's food. She stated that due to infection control concerns, once a tray was in a resident's room, the staff could not bring it out to reheat whether the resident had touched it or not.

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She stated this was to prevent infections since the staff could not be certain whether the resident had eaten any of it. She stated it might be acceptable for the staff to heat up a can of food since it was not opened, and she would have to clarify that with the staff and Administrator. She stated the staff could go to the kitchen and get another tray for the resident if needed, and if there was no food for the tray replacement in the kitchen, the resident could have a sandwich. She stated she is unsure if there is a facility policy concerning the reheating of food, or if there is a policy, what it requires. The DON confirmed the facility failed to honor the resident's choice for food to be warmed when the resident was ready to eat.

An interview with the Administrator on 4/6/23 at 1:30 PM revealed each resident has the right to warm food, but infection control issues must be considered, as well. He also stated that the staff is busy and "can't just drop what they are doing to heat his food. They might be in the middle of changing someone". The Administrator confirmed the resident has the right to have his food warmed as he prefers, and the facility is responsible for finding a solution, so residents' rights are protected, and infection control is not compromised.

Record review of the "Admission Record" revealed the facility admitted Resident #175 on 3/10/23 with a diagnosis of Cellulitis of Left Upper Limb.

Record review of Brief Interview for Mental Status (BIMS) Interview, dated 4/3/23, revealed Resident #175 had a score of 15, which indicated he was cognitively intact.

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Resident #66

An observation and interview on 4/04/23 at 09:43 AM, of the breakfast meal revealed Resident #66 had scrambled eggs on his breakfast tray. On interview the resident revealed that he requested boiled eggs daily. He revealed he had spoken to the Dietary Manager (DM) several times concerning his request for boiled eggs. He stated dietary was not consistent with his request. Resident #66 revealed that two or three days out of the week he got scrambled eggs.

Observation of the "Breakfast" meal tray ticket, dated 4/05/23, revealed, " ...Beverages Boiled Eggs ...Meal 1) Country Style Scrambled Eggs ..."

An interview with the DM on 4/06/23 at 09:15 AM revealed that she knew Resident # 66 requested boiled eggs for breakfast, and she had added the request on the dietary breakfast ticket under the beverage section. She confirmed that country style scrambled eggs are still listed on the breakfast ticket and agreed that this could be confusing and could be overlooked by the kitchen staff because the boiled egg was listed incorrectly in the beverage section of the ticket.

Review of Resident Council Minutes dated 12/06/22, 1/03/23 and 2/07/23 revealed that Resident #66 had requested boiled eggs every morning.

Record review of the facility's "Admission Record" revealed the facility admitted Resident #66 on 05/26/22 with a diagnosis of Atherosclerotic Heart Disease of Native Coronary Artery.

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

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F 806	Continued From page 23 Record review view of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/23 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.	F 806		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865		5/17/23

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F 865	Continued From page 24 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F 865		

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F 865	Continued From page 25 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review, plan of correction review, and facility policy review, the facility failed to sustain an effective Quality Assurance and Performance Improvement (QAPI) committee as evidenced by two (2) re-cited deficiencies	F 865	-The Regional Director of Operations (RDO) in-serviced the Administrator regarding the Quality Assessment and Performance Improvement (QAPI) process on 4/26/23. -All residents have the potential to be	

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F 865	Continued From page 26 originally cited in October 2022 on an annual recertification survey. Findings include: Record review of the facility policy, "QAPI Program and QAPI Committee Guidelines", (undated), revealed "QAPI Program ...V. Utilization of Root Cause Analysis ...Review the data that has been gathered and trended to identify possible areas of system breakdown and assess staff knowledge and performance"... QAPI Committee ...Once the original plan is established, the committee is responsible for: Periodically monitoring progress, Evaluating the effectiveness of the plan, Making revisions of the action plan if necessary ..." The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to correct identified issues or prevent deficiencies as follows: F656 During this recertification survey, the facility failed to develop and implement comprehensive care plans related to activities of daily living (ADL) care and range of motion. During the recertification survey in October 2022, the facility failed to develop a Comprehensive Care Plan for a resident with a diagnosis of Dementia. F761 During this recertification survey, the facility failed to ensure medications were under the direct	F 865	affected. -The RDO in-serviced all administrative staff regarding the QAPI Process including performance improvement projects (PIPS) and reviewed repeat deficiencies cited during past 24 (twenty-four) months on 4/12/23. -The RDO and Regional Nurse Consultant (RNC) will attend QAPI meetings review pips and audits provide education/guidance to the committee and document monthly beginning 5/16/23 then quarterly beginning 11/20/23 and ongoing. The RDO and RNC will submit findings from monthly then quarterly QAPI meetings to the governing body for review, revision and or resolution of the plan as needed.	

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F 865	Continued From page 27	F 865		

observation of the person administering the medication.

During the recertification survey in October 2022, the facility failed to remove expired medications from the medication storage room.

An interview on 4/5/23 at 4:40 PM, with the Regional Operations Director revealed that the Director of Nurses (DON), Assistant Director of Nurses (ADON) or Registered Nurse (RN) Supervisor completes medication pass audits, but she was unsure how often they are being done. She revealed that after the last survey the administrative staff performed 100% audit on all care plans and found more issues with care plans after their state survey.

An interview on 4/6/23 at 12:15 PM, with the Administrator revealed that he has been at the facility for 6 weeks and in that time the facility has had one QAPI meeting. He revealed he was not able to attend the one QAPI meeting the facility had due to a family emergency.

In an interview on 4/6/23 at 1:45 PM, with the Regional Director of Operations, she stated that she felt as if the facility's QAPI/QAA program is working. She said the medication pass errors were isolated incidents with that particular nurse. She stated that she felt the other repeat deficiency was caused by the inconsistency in leadership.