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 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILLS COMMUNITY LIVING 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 an Annual Recertification survey along with five (5) Compliant Investigations (CI MS #3185590, CI MS #3055871, CI MS #3049319, CI MS #3048639, and CI MS #3176412) at the facility from 8/31/26 through 9/3/26. CI MS #3048639 was investigated for quality of care, dignity and respect and accidents. CI MS #3049319 was investigated for resident safety, CI MS #3055871 was investigated for environment, CI MS #3185590 was investigated for neglect and quality of care. There were no citations related to these CIs. CI MS# 3176412 was investigated for falls and F689 was cited. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F628, F600, F557, F561, F609, F610, F645, F677, F688, and F867. The facility had a census of 80 and was licensed for 100 beds.	F0000		
F0689 SS = G	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 ensure a resident with known behaviors was provided adequate supervision during transportation to prevent accidents, as evidenced by Resident #17 falling in the facility transportation van on two (2) occasions after repeatedly releasing the wheelchair	F0689		

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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F0689 SS = G	Continued from page 1 safety belt. This deficient practice affected one (1) of (19) sampled residents reviewed for accidents and supervision and resulted in Resident #17 sustaining a head injury requiring emergency medical evaluation. Findings Include: Record review of the facility policy “Accident/Incidents,” undated, revealed the purpose of the policy was to ensure that persons involved in an incident or accident were evaluated, received treatment as indicated, and were monitored for disposition of the incident or accident. Record review of the facility policy "Transportation Vehicle Policy and Procedure,” undated, revealed the purpose was to provide transportation in a safe manner according to state laws and guidelines and that only trained transportation staff would utilize the van/bus lift for transports. Record review of the Center for Medicare and Medicaid Services (CMS) Form 2567 dated 2/23/26 revealed the facility had previously been cited for failing to properly secure a wheelchair security device and prevent an accident involving a resident who depended on the facility van and staff for transportation to medical appointments. A record review of the hospital "History and Physical" dated 8/24/26 revealed Resident #17 was admitted to the hospital following a fall in the facility van. The record indicated Resident #17 sustained a laceration to the back of the head, right-sided weakness, complained of blindness in the right eye, and experienced a temporary loss of consciousness. On 9/1/26 at 9:00 AM, Resident #17 stated he had experienced two (2) falls while being transported from dialysis in the facility van. Resident #17 stated the Certified Nursing Assistants (CNAs) failed to secure him in his wheelchair to prevent him from falling. On 9/1/26 at 9:15 AM, Resident #17’s son stated Resident #17 had experienced (2) falls while being transported from dialysis. He stated Resident #17 had told him that the CNAs were not securing his wheelchair. The son also stated the facility had told the family that Resident #17 continued to release the self-releasing seat belt while in the van. On 9/1/26 at 11:00 AM, Resident #6 (who was on the van when the incident occurred) stated Resident #17 was attempting to release his seat belt during	F0689		

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F0689 SS = G	Continued from page 2 transportation from dialysis on 8/24/26. Resident #6 stated she repeatedly told the transportation CNAs that Resident #17 would not leave his wheelchair alone and that he was always releasing his seat belt. On 9/1/26 at 1:00 PM, during observation of Resident #17 being transported in the facility van, CNA #5 pushed the resident's wheelchair onto the ramp and initially failed to secure the wheelchair to the van. CNA #5 subsequently secured the wheelchair and safety belt. The observation further revealed Resident #17 was able to release the self-releasing seat belt used to secure him in the wheelchair. On 9/1/26 at 1:20 PM, CNA #4 stated Resident #17 repeatedly attempted to release the wheelchair straps and self-releasing seat belt during transportation. CNA #4 stated that following a previous fall, the Administrator instructed the transportation CNAs that one CNA was to always sit in the back of the van with the residents. CNA #4 stated she was driving and CNA #5 was responsible for sitting in the back; however, CNA #5 remained in the passenger seat. CNA #4 stated that if someone had been sitting in the back with the residents, Resident #17 "probably would not have fallen." On 9/1/26 at 1:30 PM, CNA #5 stated Resident #17 repeatedly attempted to release the safety belt and required repeated redirection. CNA #5 acknowledged she sat in the front passenger seat during transportation and was aware Resident #17 had previously attempted and successfully released the safety belt. On 9/2/26 at 9:00 AM, CNA #3 stated the Administrator had instructed the transportation aides after the previous February incident that someone was to always sit in the back seat with residents. CNA #3 stated CNA #5 was unable to get up in time to prevent Resident #17 from falling from the wheelchair. On 9/2/26 at 10:00 AM, the Administrator confirmed Resident #17 fell backwards in the transportation van on 8/24/26 after attempting to manipulate the wheelchair locking mechanism. The Administrator stated she had previously instructed the transportation CNAs in February that one CNA should sit in the back of the van with residents to prevent further falls. The Administrator acknowledged she did not provide a written in-service regarding the instruction. She stated the CNAs failed to follow her instructions and that following the instruction could have prevented	F0689		

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F0689 SS = G	Continued from page 3 Resident #17 from falling on 6/16/26 and 8/24/26. On 9/3/26 at 3:13 PM, the Director of Nursing (DON) confirmed the Administrator had instructed the transportation CNAs in February that one CNA should ride in the back with residents to prevent further falls. The DON confirmed the transportation CNAs failed to follow the Administrator's instruction and stated that following the instruction could possibly have prevented the resident from falling. A record review of the Employee Corrective Coaching Form dated 8/24/26 revealed CNA #5 was suspended for five (5) days following the safety incident. A record review of the Employee Corrective Coaching Form dated 8/24/26 revealed CNA #4 was reprimanded for not following the appropriate transportation van safety procedure. A record review of the facility "Admission Record" revealed Resident #17 was admitted on 3/16/26 with diagnoses that included Stage 5 kidney disease and Left Below Knee Amputation. A record review of residents'17's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/24/26 revealed a staff assessment was completed with no Brief Interview for Mental Status (BIMS) score documented. Staff assessed Resident #17 for cognitive skills for daily decision making and coded a two (2) which indicated the resident had moderate cognitive impairment and made poor decisions; cues/supervision were required. Section G indicated the resident needed a wheelchair for transportation. Resident #6 A record review of the facility "Admission Record" revealed the resident was admitted on 3/31/26 with diagnoses that included End stage renal disease, and renal dialysis A record review of resident's Quarterly MDS with an ARD of 6/26/26 revealed a BIMS score of 10 which indicated the resident had moderate cognitive impairment.	F0689		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600		

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F0600 SS = E	Continued from page 4 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents were free from physical and verbal abuse, intimidation, and fear of retaliation from facility staff for four (4) of (19) sampled Residents. Resident #4, #29, #57 and #82. Findings include: Record review of the facility policy, “Abuse and Neglect Policy and Procedure,” undated, revealed, “Purpose: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff…Policy: To provide a safe environment for all residents free of abuse…” Record review of the facility investigation received post annual survey dated 9/8/26 revealed additional residents and staff who also witnessed the alleged abuse were identified during the annual survey by the State Agency (SA). Resident #29 During an interview on August 31, 2026, at 11:46 AM, Resident #29 stated she has asthma, is currently on oxygen, and receives breathing treatments every six hours as needed. She reported that on weekends, Registered Nurse (RN) #1 refuses to provide her breathing treatments when requested. Resident #29 stated RN #1 makes statements such as, “I will give you the medication when I feel like it, I do not care about every six hours.” Resident #29 reported it is sometimes eight (8) to ten (10) hours before RN #1 administers the treatment after she asks. She stated	F0600		

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F0600 SS = E	Continued from page 5 she continues to wheeze, experiences chest tightness, and remains congested until RN #1 decides to bring the treatment. Resident #29 stated she is not comfortable with (RN #1) due her becoming irate when asked about medications or questioned. Resident #29 reported she has not informed the Administrator due to fear of retaliation, noting that no administrative staff are present on weekends and she is concerned about how RN#1 will treat her when Administration is not in the building. In a follow-up interview with Resident #29 on September 2, 2026, at 9:48 AM (Administrator Present), she re-stated that she is not comfortable with RN #1. She informed the Administrator she experiences RN #1 as abrasive, abusive, and intimidating. Resident #29 stated she fears what RN#1 could potentially do to her and worries that RN#1 may one day refuse to give her medication out of spite. A record review of the "Admission Record" revealed the facility admitted Resident#29 on 8/5/26 with diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified and Shortness of Breath. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/11/26 revealed a Brief Interview for Mental Status of (14) indicating Resident #29 is cognitively intact. Resident #4 During an interview on September 1, 2026, at 11:36 AM Resident #4 stated (RN #1) passes his medications in the evenings and on weekends. He reported that many interactions with her are difficult because she is rude and yells at him. Resident #4 stated he reported this to the Administrator about a month ago, and she told him she would look into it, but he never received follow-up. He stated RN #1 continues to come into his room, and he feels nothing will be done to address his concerns. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 8/25/23 with diagnoses including Anxiety Disorder, Unspecified A record review of the quarterly MDS with an ARD of 7/7/26 revealed a BIMS score of (15) indicating Resident #4 is cognitively intact. Resident #82 During an interview on September 1, 2026, at 11:41	F0600		

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F0600 SS = E	Continued from page 6 AM Resident #82 stated that during multiple interactions, RN #1 has rudely told her to “shut up” and she has observed RN #1 saying this to other residents while staff were present. Resident #82 stated the Administrator has also witnessed this behavior, and nothing was done. A record review of the "Admission Record" revealed the facility admitted the Resident#82 on 8/6/26 with diagnoses including Depression Unspecified. A record review of the admission MDS with an ARD of 8/12/26 revealed a BIMS score of (15) indicating Resident #82 is cognitively intact. Resident #57 Resident #57 stated in an interview on 9/1/26 at 12:19 PM, that she was happy to be moved to the other side of the building to ensure RN #1 would no longer be her medication nurse. She reported RN #1 was rude during many interactions. Resident #57 stated interactions with RN #1 increased her anxiety and made her nervous day-to-day because she did not like the way RN#1 spoke to her. A speaker phone interview was conducted with RN#1 on 9/2/26 at 8:43 AM, with several State Agency members (SA) present. RN #1 acknowledged she was rehired at the facility in April 2026 to work as a medication nurse. She recalled being terminated in April 2024 when the regional staff informed her, she was being let go due to resident reports that she was “hollering” and mean. RN #1 stated she is naturally loud and accepted the termination without rebuttal. When informed of current complaints, RN #1 stated she is “not going to say she does not have her days,” and admitted she sometimes comes to work “in a mood,” acknowledging she can understand why residents would say she is rude. She stated it is not right for her to behave that way, and she should be respectful, calm, and treat residents with dignity. She stated she is “still working on that.” During an interview on 09/02/26 at 10:10 AM, Resident #57 stated that in late March or April 2026, Licensed Practical Nurse (LPN) #1 entered her room to administer pain medication. Resident #57 stated she asked LPN #1 questions about the medication, including when it was due and the prescribed dosage. She stated LPN #1 placed the medication cup and a cup of water on the bedside table. Resident #57 picked up both cups and continued asking questions about the medication. Resident #57 stated LPN #1 told her, “I will take those pills from	F0600		

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F0600 SS = E	Continued from page 7 you if you don't take them." Resident #57 stated LPN #1 reached for the medication cup while it was in her hand. She stated she held the medication cup tightly, but LPN #1 pried her hand open and removed the cup. Resident #57 stated LPN #1 then exited the room.Resident #57 stated Certified Nursing Assistant (CNA) #2 was present and witnessed the incident. Resident #57 stated the incident made her feel sad and angry, but she was not afraid of LPN #1. She stated she called the Nursing Home Administrator (NHA) and left a message requesting that the NHA speak with her on Monday morning regarding the incident. Resident #57 stated the NHA did not return her telephone call. She stated she spoke with the NHA that Monday and reported what had occurred. Resident #57 stated the NHA asked whether she had a witness and told her that she would investigate the incident and follow up with her. Resident #57 stated the NHA never informed her of the results of an investigation. During an interview on 09/02/26 at 10:37 AM, the NHA initially denied knowledge of the incident. The NHA then recanted her statement and acknowledged that she remembered the incident. The NHA stated she spoke with Resident #57 and LPN #1. She stated Resident #57 reported that she was asking questions about her medication, but the NHA could not recall all the information Resident #57 provided. The NHA stated LPN #1 denied prying Resident #57's hand open or taking the medication from her hand. She stated LPN #1 reported that Resident #57 refused to take the medication. The NHA acknowledged that she did not conduct an investigation or report the allegation to the State Agency. She stated, in hindsight, she should have reported the allegation. The NHA stated she spoke with both parties, but the incident did not register with her as possible abuse. She confirmed Resident #57 reported that LPN #1 placed her hands on her. The NHA stated LPN #1 worked long shifts and sometimes came to work irritated or upset, which carried over into the care provided to residents. The NHA stated she had written statements from CNA #2 and LPN #1 but would have to locate them. A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/16/22 with diagnoses including Anxiety Disorder Unspecified. A record review of the quarterly MDS with an ARD of 7/14/26 revealed a BIMS score of (13) indicating Resident #57 is cognitively intact. On 9/1/26 at 12:49 PM, the Administrator stated she did not learn about the prior complaints until after	F0600		

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F0600 SS = E	Continued from page 8 rehiring RN #1. She stated no concerns had been brought to her recently regarding RN#1, so she assumed everything was fine. The Administrator acknowledged RN #1 was terminated in April 2024 due to the way she spoke to and treated residents. She stated RN #1 was recently rehired because she was not on the “Do Not Rehire” list, so she assumed it was acceptable. During an interview on 9/3/26 at 8:15 AM, the Administrator stated Resident #4 had complained to her about how RN #1 spoke to him. Regarding Resident #82, the Administrator acknowledged she also had an incident involving RN #1 but believed she had resolved it and did not know concerns were ongoing. The Administrator stated she expects staff to show compassion, patience, courtesy, and to be mindful of their tone. She stated residents have the right to feel safe, to choose how they receive medications, and to report grievances without fear of retaliation. During an interview on 9/3/26 at 4:37 PM, the Director of Nursing (DON) denied any knowledge of RN #1’s behavior but acknowledged RN #1 should not speak rudely or harshly to residents because such behavior is threatening, can cause depression, and may make residents uncomfortable communicating their needs. A record review of the facility “Employment Record” for RN#1 revealed she was terminated effective 4/5/24. A record review of the facility "Employment Record" for RN#1 revealed she was rehired on 4/7/26 and had currently been employed at the facility for 4 months. A record review of the “Employee Timecard” reveals RN#1 most recently worked on 8/28/26, 8/29/26 and 8/30/26.	F0600		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0628		

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F0628 SS = E	Continued from page 9 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be	F0628		

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F0628 SS = E	Continued from page 10 endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of	F0628		

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 09/03/2026

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F0628 SS = E	Continued from page 11 individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold	F0628		

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F0628 SS = E	Continued from page 12 policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to provide written notification to the Resident Representatives (RR) regarding hospital transfers, including the reason for each transfer for four (4) of (19) sampled residents. Residents #17, #53, #80, and #84. Findings include: A record review of the facility's policy titled "Resident Rights," revised 11/28/2016, revealed the facility must immediately inform the resident, consult with the resident's physician, and notify the resident representative, consistent with the representative's authority, when the facility decides to transfer or discharge the resident. During an interview on 9/1/2026 at 9:34 AM, Resident #80 stated he had been hospitalized because of his wounds. He could not recall the number of hospitalizations related to his wounds. During an interview on 9/2/2026 at 2:50 PM, the Nursing Home Administrator stated the corporate office changed the facility's hospitalization notification form in January 2026. She stated the revised form did not include the reason for the transfer. She confirmed that, since the form was changed, the facility had not notified resident representatives in writing of the reasons residents	F0628		

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F0628 SS = E	Continued from page 13 were transferred to the hospital. The Nursing Home Administrator stated written notification was important to keep representatives informed of residents' conditions. She stated a representative could become worried or upset if the hospital notified the representative of the transfer before the nursing home provided the information. She confirmed the facility failed to provide the representatives of Residents #17, #53, #80, and #84 with written notification of the reasons the residents were transferred to the hospital. Upon request for the written hospital transfer notifications for Residents #17, #53, #80, and #84, the Nursing Home Administrator was unable to provide documentation showing that the facility notified the residents' representatives in writing of the transfers and the reasons for the transfers. Resident #17A record review of Resident #17's "Admission Record" revealed the facility admitted the resident on 3/16/2026 with diagnoses that included chronic obstructive pulmonary disease. A record review of Section A of Resident #17's Discharge Minimum Data Set assessment, with an Assessment Reference Date (ARD) of 8/24/2026, revealed the resident was discharged to the hospital on 8/24/2026. Further review of Resident #17's "Progress Notes" revealed the facility transferred the resident to the hospital on 5/9/2026 after the resident became unresponsive, on 6/16/2026 after the resident fell in the facility van and struck the resident's head and on 8/24/2026 after another incident involving a fall in the facility van. A record review revealed the facility did not provide written documentation showing that Resident #17's representative received notice of the hospital transfers and the reasons for the transfers. Resident #53 A record review of Resident #53's "Admission Record" revealed the facility admitted the resident on 6/1/2024 with diagnoses that included sepsis due to Escherichia coli. A record review of Section A of Resident #53's Discharge Minimum Data Set assessment, with an ARD of 5/14/2026, revealed the resident was discharged from the facility to the hospital. A record review revealed the facility did not provide	F0628		

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F0628 SS = E	Continued from page 14 written documentation indicating that Resident #53's RR received notice of the hospital transfer and the reason for the transfer. Resident #80 A record review of Resident #80's"Admission Record" revealed the facility admitted the resident on 10/18/2023 with diagnoses that included osteomyelitis of the sacral and sacrococcygeal region and a Stage 4 pressure ulcer of the right hip. A record review of Resident #80's "Progress Notes" revealed the facility transferred the resident to the emergency room due to concerns related to the resident's wounds. A record review revealed the facility did not provide written documentation showing that Resident #80's representative received notice of the hospital transfer and the reason for the transfer. Resident #84 A record review of Resident #84's "Admission Record" revealed the facility admitted the resident on 9/21/2017 with diagnoses that included chronic obstructive pulmonary disease and atherosclerotic heart disease of the native coronary artery without angina pectoris. A record review of a "Health Status Note" dated 6/20/2026 at 8:19 AM revealed staff observed purulent drainage from Resident #84's anus. The resident had a blood pressure of 115/63, a pulse of 125, malaise, and requested transfer to the emergency room. Staff reported the resident's condition to two nurse practitioners. A record review of a "Health Status Note" dated 6/20/2026 at 8:31 AM revealed staff received an order to transfer Resident #84 to the emergency room and notified the ambulance service. A record review revealed the facility did not provide written documentation showing that Resident #84's RR received notice of the hospital transfer and the reason for the transfer.	F0628		
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F0557		

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F0557 SS = D	Continued from page 15 and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to permit residents to retain and use personal possessions when staff removed snacks from a resident room without consent and stored them in a locked office that the resident could not independently access for one (1) of (18) sampled residents. Resident #57. Findings include: Record review of the facility policy “Resident Personal Property “undated, revealed "…Residents are permitted to retain and use personal possessions, including furniture and clothing as space permits…" On 08/31/2026 at 11:42 AM, during an interview, Resident #57 stated staff removed a blue tote containing her snacks from her room and placed it near the Social Worker’s (SW) office. Resident #57 stated staff did not ask for her permission before removing the tote. She stated staff told her that she could request a snack and they would bring it to her. Resident #57 stated she wanted her snacks returned to her room. On 09/01/26 at 11:00 AM, during an interview, Resident #57’s Resident Representative (RR) stated facility staff told him the refrigerator was freezing up, would not maintain the appropriate temperature, and was not being kept clean. He stated the refrigerator had been purchased new approximately six months before the facility instructed him to remove it. He stated facility staff also reported that Resident #57 kept old food in the refrigerator. The RR stated the SW contacted him approximately six months earlier and instructed him to remove the refrigerator and other belongings. On 09/01/2026 at 3:45 PM, during an observation and interview, the SW's office contained five cases of soda and numerous bags of residents’ snacks. The SW stated she stored residents’ snacks in her locked office because snacks had disappeared from residents’ rooms. She stated the facility did not know whether staff or other residents were taking	F0557		

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F0557 SS = D	Continued from page 16 the snacks. The SW stated residents were asked about their snacks on Fridays and received snacks on Fridays. She confirmed residents could not access their snacks when she or the maintenance employee was unavailable because the office remained locked and no other staff had access. On 09/02/2026 at 4:06 PM, during an interview, the SW described Resident #57 as a “hoarder” and stated Resident #57 placed food in bins. The SW stated staff informed Resident #57 that they were removing the bin containing her snacks and placing it near the SW's office. She stated Resident #57 did not agree or disagree with the removal of the bin. On 09/02/2026 at 4:28 PM, during an interview, the Nursing Home Administrator (NHA) confirmed Resident #57’s snack bin was stored near the SW’s office. On 09/03/2026 at 1:30 PM, during an interview, the SW stated Resident #57 could have her snacks returned to her room but could not retain the original bin because its size created a fall risk. She stated the facility had purchased a smaller bin and planned to place it in Resident #57’s room. On 09/03/2026 at 3:44 PM, during an interview, the Director of Nursing (DON) stated she knew staff had placed Resident #57’s snack bin near the SW’s office. She stated staff could contact her for the office code to retrieve Resident #57’s snacks. The DON stated she did not know whether residents had been informed of their choices regarding access to their snacks. On 09/03/2026 at 5:04 PM, during an interview, the NHA stated Resident #57 should have snacks in her room so she could eat them at will. The NHA confirmed other residents retained snacks in their rooms. Record review of Resident #57’s “Admission Record” revealed an admission date of 08/16/2022 and diagnoses that included need for assistance with personal care, unilateral primary osteoarthritis of the left knee, and anxiety disorder. Record review of Resident #57’s Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 07/14/2026, revealed a Brief Interview for Mental Status score of 13, which indicated Resident #57 was cognitively intact.	F0557		

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F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and facility policy review the facility failed to ensure residents were able to make choices related to keeping a personal refrigerator in the room for one (1) of (18) sampled residents. Residents #57 Findings Include: Record review of the facility policy review of the facility's "Residents Rights and Quality of Life Policy and Procedure" undated revealed...All residents have the right to a dignified existence, self-determination…" Policy review of the facility's "Resident Personal Property" undated revealed, "Residents are permitted to retain and use personal possessions, including furniture and clothing as space permits…"	F0561		

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F0561 SS = D	Continued from page 18 Record review of the facility policy “Food from Outside Sources" with a revision date of 1/12/26 revealed participants will learn that food brought in by visitors, family, or other guests for residents is permitted allowing the residents the rights to choose. The community does have the responsibility to help staff and visitors understand safe food handling practices. Perishable food should be sealed and dated with a use by date and placed in refrigeration. The community will designate who will record the temperature of resident’s refrigerators in their rooms and or nourishment room refrigerators. The community will also designate who will be responsible for cleaning the refrigerators and who will discard outdated or uneaten foods after reviewing this need with the residents. On 08/31/2026 at11:42 AM, in an interview Resident #57 stated the Nursing Home Administrator (NHA) informed her that she could not keep the refrigerator clean and could no longer keep it in her room. The NHA called the Resident Representative (RR) to come get refrigerator. She stated she was very upset because other residents have refrigerators in their rooms. She stated some have two in their room. On 09/01/26 at 11:00 AM, in an interview Resident #57's RR stated they told her she could not keep the refrigerator in the room as it was freezing up and would not keep a safe temperature. He stated the refrigerator was brought brand new 6 months ago. He stated she was told she could not keep it clean. He stated they also told him that she had old food in the refrigerator. He stated he was contacted by the Social Worker (SW) to come get the refrigerator and other items about 6 months ago. He stated Resident #57 was very upset about the refrigerator. He stated he has never brought food to the facility daily. He stated he has never brought her unshelled peas, corn or mushrooms. He stated he had never brought her uncooked food. He stated he usually brings food on the weekend. On 09/02/26 at 4:06 PM, in an interview the SW stated residents were keeping unshelled peas, old shrimp and mushrooms in the fridge. The SW stated that Resident #57 did not want the Certified Nursing Assistants (CNAs) to go in the refrigerator. She stated they discussed it with the RR about not bringing a lot of stuff for her refrigerator. She stated after a week cooked peas needed to be disposed of. She stated residents would have pig feet in the refrigerator, and the food would get mold on it. She started to phone the RR to come and get the refrigerator. She stated Resident #57 is a "hoarder."	F0561		

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F0561 SS = D	Continued from page 19 She stated the food in the fridge could make her sick. She stated the facility wanted it out due to odors in the refrigerator and gnats in the room. She stated the facility cleaned the refrigerator. She confirmed that the residents had a right to have a refrigerator and stated she felt like the resident should be able to have a refrigerator in her room On 09/02/26 at 4:28 PM, in an interview the NHA stated Resident #57 is a "hoarder." She stated we care planned it with RR. She stated residents would keep molded food in the refrigerator. She stated the RR would bring pig feet and watermelon. She stated their policy states the resident or RR are supposed clean the refrigerator. She stated the RR brings food to her and puts it in her refrigerator. She stated the refrigerator was causing gnats to come into the room. She stated the staff would clean the refrigerator out and recheck it in three (3) weeks and find molded food in it. She stated they did not check the refrigerator daily. She stated they did not date and label food that the RR brought in. She confirmed that the facility policy revealed food brought in by family should be dated and labeled. She confirmed they did not follow policy. On 09/03/26 at 1:30 PM, in an interview the SW stated the refrigerator will not be returned to Resident #57 due to safety hazards of molded food and maggots in it. On 09/03/26 at 3:44 PM, an interview the Director of Nursing (DON) stated she was aware of Resident #57's refrigerator being removed from the facility. She stated she was not the DON when it happened. She stated she did not witness any molded food or maggots in the refrigerator. On 09/03/26 at 5:05 PM, in an interview the NHA confirmed that they will meet with the RR and Resident #57 and come up with a plan and allow resident to get the refrigerator back in her room. Record review of Resident #57 "Admission Record" revealed an admission date of 08/16/22 with diagnoses of need for assistance with personal care, unilateral primary osteoarthrosis left knee, major depression disorder and anxiety disorder. Record review of Resident #57's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F0561		

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F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and facility policy review the facility failed to report an allegation of abuse for one (1) of (1) alleged abuse reported to the facility. Resident #57 Findings Include: Record review of the facility policy “Reporting of Crime Policy and Procedure” undated, revealed "Purpose: to ensure reporting of crime against a resident or individual receiving care from the facility occurring in the nursing home within the prescribed timeframes to the appropriate entities....2. The facility will adhere to the following policy to ensure timely reporting of crimes: Any reasonable suspicion of crime against a resident shall be reported immediately to the facility administrator, State Agency…" During an interview on 09/02/26 at 10:10 AM,	F0609		

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F0609 SS = D	Continued from page 21 Resident #57 stated that in late March or April 2026, Licensed Practical Nurse (LPN) #1 entered her room to administer pain medication. Resident #57 stated she asked LPN #1 questions about the medication, including when it was due and the prescribed dosage. She stated LPN #1 placed the medication cup and a cup of water on the bedside table. Resident #57 picked up both cups and continued asking questions about the medication. Resident #57 stated LPN #1 told her, “I will take those pills from you if you don’t take them.” Resident #57 stated LPN #1 reached for the medication cup while it was in her hand. She stated she held the medication cup tightly, but LPN #1 pried her hand open and removed the cup. Resident #57 stated LPN #1 then exited the room.Resident #57 stated Certified Nursing Assistant (CNA) #2 was present and witnessed the incident. Resident #57 stated the incident made her feel sad and angry, but she was not afraid of LPN #1. She stated she called the Nursing Home Administrator (NHA) and left a message requesting that the NHA speak with her on Monday morning regarding the incident. Resident #57 stated the NHA did not return her telephone call. She stated she spoke with the NHA that Monday and reported what had occurred. Resident #57 stated the NHA asked whether she had a witness and told her that she would investigate the incident and follow up with her. Resident #57 stated the NHA never informed her of the results of an investigation. During an interview on 09/02/26 at 10:37 AM, the NHA initially denied knowledge of the incident. The NHA then recanted her statement and acknowledged that she remembered the incident. The NHA stated she spoke with Resident #57 and LPN #1. She stated Resident #57 reported that she was asking questions about her medication, but the NHA could not recall all the information Resident #57 provided. The NHA stated LPN #1 denied prying Resident #57’s hand open or taking the medication from her hand. She stated LPN #1 reported that Resident #57 refused to take the medication. The NHA acknowledged that she did not conduct an investigation or report the allegation to the State Agency. She stated, in hindsight, she should have reported the allegation. The NHA stated she spoke with both parties, but the incident did not register with her as possible abuse. She confirmed Resident #57 reported that LPN #1 placed her hands on her. The NHA stated LPN #1 worked long shifts and sometimes came to work irritated or upset, which carried over into the care provided to residents. The NHA stated she had written statements from CNA #2 and LPN #1 but would have to locate them.	F0609		

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 09/03/2026

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F0609 SS = D	Continued from page 22 During a telephone interview on 09/02/26 at 2:29 PM, LPN #1 stated Resident #57's pain medication had been changed because the resident had been overly sedated. LPN #1 stated she explained the medication change to Resident #57. She stated Resident #57 was known to retain medications and not take them in the nurse's presence. LPN #1 stated she had previously found pills on the floor and bed in Resident #57's room. She acknowledged that she did not report the medications found in the room or document the findings in the resident's medical record. LPN #1 stated Resident #57 continued asking questions about the medication and that she continued answering the questions. She stated Resident #57 held the medication and did not take it. LPN #1 stated she waited approximately 20 minutes, picked up the pills from the bedside table, and exited the room. LPN #1 denied taking the medication cup from Resident #57's hand. During an interview and demonstration on 09/02/26 at 3:15 PM, CNA #2 stated she was present when the incident occurred. CNA #2 stated Resident #57 asked LPN #1 about her medication. She stated LPN #1 responded, "I told you already," and instructed Resident #57 to take the medication immediately. CNA #2 stated Resident #57 held the medication cup in one hand and the cup of water in the other hand while asking LPN #1 to explain the medication again. CNA #2 stated LPN #1 attempted to take the medication cup from Resident #57's hand, and LPN #1 and Resident #57 tussled over the cup. CNA #2 stated the water spilled onto Resident #57's gown during the incident. She stated LPN #1 then exited the room. CNA #2 demonstrated three times how LPN #1 and Resident #57 tussled over the medication cup. CNA #2 stated she returned to check on Resident #57 after the incident. Record review of Resident #57's "Admission Record" revealed an admission date of 08/16/22 and diagnoses that included need for assistance with personal care, unilateral primary osteoarthritis of the left knee, and anxiety disorder. Record review of Resident #57's Minimum Data Set assessment, with an Assessment Reference Date of 07/14/26, revealed a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Record review of CNA #2's written statement revealed that LPN #1 picked up the medications from the bedside table and exited the room. The written statement did not document CNA #2's account provided during the 09/02/26 interview that LPN #1	F0609		

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F0609 SS = D	Continued from page 23 and Resident #57 tussled over the medication cup, that LPN #1 pried Resident #57's hand open, or that water spilled onto the resident's gown.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an allegation of possible staff-to-resident physical abuse for one (1) of (1) residents reviewed for abuse, Resident #57. Findings Include: Record review of the facility's "Reporting of Crime Policy and Procedure" undated, revealed "To ensure reporting of crime against a resident or individual receiving care from the facility occurring in the nursing home within the prescribed timeframes to the appropriate entities. Policy: The facility will adhere to the following policy to ensure timely reporting of crimes...2. Any reasonable suspicion of crime against a resident shall be reported immediately to the facility administrator, State Agency… Record review of the facility policy "Incidents accidents Policy" undated revealed, "Purpose...: To assure that all persons who are involved in an incident or accident, or suspected to have had an incident or accident, are evaluated and receive	F0610		

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F0610 SS = D	Continued from page 24 treatment as indicated and are monitored for disposition of incident and accident... Policy: Incident and accidents are to be...investigated and followed up in a timely manner...." During an interview on 09/02/26 at 10:10 AM, Resident #57 stated that in late March or April 2026, Licensed Practical Nurse (LPN) #1 entered her room to administer pain medication. Resident #57 stated she asked LPN #1 questions about the medication, including when it was due and the prescribed dosage. LPN #1 placed the medication cup and a cup of water on the bedside table. Resident #57 stated she picked up the medication cup and water and continued asking questions. According to Resident #57, LPN #1 stated, “I will take those pills from you if you don’t take them.” Resident #57 stated LPN #1 reached for the medication cup while it was in her hand. Resident #57 held the cup tightly, and LPN #1 pried her hand open and removed the medication cup. LPN #1 then exited the room. Resident #57 stated Certified Nursing Assistant (CNA) #2 witnessed the incident. Resident #57 stated she felt sad and angry about how LPN #1 treated her. She called the Nursing Home Administrator (NHA) and left a message asking the NHA to speak with her on Monday morning. Resident #57 stated the NHA did not return her call. Resident #57 stated she spoke with the NHA that Monday, and the NHA asked whether anyone witnessed the incident. Resident #57 identified CNA #2 as a witness. The NHA told Resident #57 that she would investigate the incident and follow up with her. Resident #57 stated the NHA never provided any follow-up regarding the incident. During an interview on 09/02/26 at 10:37 AM, the NHA initially denied knowledge of the incident but immediately recanted and stated she remembered it. The NHA stated Resident #57 reported that she was asking questions about her medication. The NHA stated she could not recall all the information Resident #57 provided. The NHA stated she spoke with Resident #57 and LPN #1. According to the NHA, LPN #1 denied prying Resident #57’s hand open and taking the medication. LPN #1 told the NHA that Resident #57 refused to take the medication. The NHA acknowledged that Resident #57 reported that LPN #1 placed her hands on the resident. The NHA stated she did not conduct a thorough investigation or report the allegation to the State Agency. The NHA stated, “Honestly, I talked to both parties, and it did not register to me as possible abuse.” The NHA acknowledged that, in hindsight, she should have conducted a thorough investigation. The NHA also stated LPN #1 worked	F0610		

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F0610 SS = D	Continued from page 25 long shifts, sometimes came to work irritated or upset, and allowed that irritation to carry over into the care of residents. The NHA stated she had written statements from CNA #2 and LPN #1 but would have to locate them. During a telephone interview on 09/02/26 at 2:29 PM, LPN #1 stated Resident #57's pain medication had been changed because the resident was overly sedated. LPN #1 stated she explained the medication change to Resident #57. LPN #1 stated Resident #57 was known to retain medications instead of taking them in the nurse's presence. LPN #1 stated she previously found medications on the floor and bed in Resident #57's room but did not report or document those findings. LPN #1 stated Resident #57 continued asking questions about the medication and did not take the medication after approximately 20 minutes. LPN #1 denied physically taking the medication cup from the resident's hand. LPN #1 stated she picked up the medication from the bedside table and exited the room. During an interview and demonstration on 09/02/26 at 3:15 PM, CNA #2 stated she witnessed the incident. CNA #2 stated Resident #57 asked LPN #1 questions about the medication. CNA #2 stated LPN #1 responded, "I told you already," and instructed Resident #57 to take the medication immediately. CNA #2 stated Resident #57 held the medication cup in one hand and the cup of water in the other while asking LPN #1 to explain the medication again. CNA #2 stated LPN #1 attempted to take the medication cup from Resident #57's hand, and LPN #1 and Resident #57 tussled over the medication cup. CNA #2 stated the resident's water spilled onto her gown during the struggle. CNA #2 demonstrated three times how LPN #1 and Resident #57 struggled over the medication cup. CNA #2 stated LPN #1 then exited the room, and CNA #2 later returned to check on Resident #57. Record review of Resident #57's "Admission Record" revealed an admission date of 08/16/22 with diagnoses that included need for assistance with personal care, unilateral primary osteoarthritis of the left knee, and anxiety disorder. Record review of Resident #57's Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 07/14/26, revealed a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Record review of LPN #1's personnel file revealed she resigned from the facility on 04/27/26.	F0610		

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F0610 SS = D	Continued from page 26 Record review of CNA #2's written statement revealed LPN #1 picked up the medication from the bedside table and exited the room. However, during the interview on 09/02/26 at 3:15 PM, CNA #2 stated and demonstrated that LPN #1 physically struggled with Resident #57 to remove the medication cup from the resident's hand.	F0610		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F0645		

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F0645 SS = D	Continued from page 27 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to refer a resident with a known mental illness diagnosis for a Level II Preadmission Screening and Resident Review (PASARR) when the resident had a change in condition and began treatment for the mental illness for one (1) of (1) residents reviewed for mental illness. Resident #80. Findings Include: On 09/01/2026 at 3:30 PM, in an interview with Social Worker (SW) stated that a Level II is done when a resident is admitted with a mental illness. She stated when Resident #80 had a change of condition and medication was started to treat Paranoid Schizophrenia, she should have submitted a Level II screening on 10/25/25. She stated the	F0645		

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F0645 SS = D	Continued from page 28 reason for doing a Level II is to give the facility approval for nursing home placement. It informs the facility of a better way to give care. It also gives them suggestions on how to care for them better. She stated she got a written response from (Proper name of screening company) revealing if changes occur or new information refutes then a new screen must be submitted. Record review of Resident #80 "Admission Record" revealed an admission date of 10/18/23 with diagnoses that included of Paranoid Schizophrenia. Record review of Resident #80 "Order Summary Report" with active orders as of 9/1/26, revealed an order with a start date of 10/21/25 for Risperdal Oral Tablet 1 MG (milligrams)(Risperidone) Give 1 tablet by mouth two times a day related to Paranoid Schizophrenia. Record review of Resident #80's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 6/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact. Record review of Resident #80's "Notice of Negative Level 1 Screen Outcome" with a review date of 10/23/23 revealed, "The PASRR Level 1 re-review Identification Screen...shows that nursing facility placement is appropriate for you...Level II not required on admission...PASRR Determination Part 1...this Level I is approved with a Level 1 negative outcome. If changes occur or new information refutes these findings a new screen must be submitted..." Preadmission screening revealed Level two is not required on admission.... Disease Diagnosis 4- Paranoid schizophrenia- 3-Diagnosis present, monitored but no active treatment. Section I indicated there were no medications listed related to the diagnosis of Paranoid Schizophrenia. Record review of Resident #80's Preadmission screening revealed from (Proper name of screening company) per level one submission and information provided, A level II evaluation is not required, and this level I is approved with a Level I negative outcome. If changes occur or new information refutes these findings a new screen must be admitted. The facility did not provide a PASSAR policy about significant change.	F0645		

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F0677 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 observation, interview, and record review, the facility failed to provide necessary activities of daily living (ADL) care, specifically fingernail and hand hygiene care for two (2) of (19) sampled residents reviewed for nail care and contracture management. Residents #13 and #20. Findings include: Record review of the facility policy “ADL Care of a Resident Policy and Procedure” revealed activities of daily living care would be provided according to each resident’s individualized needs. The policy directed staff to provide care specific to the resident’s needs to achieve the most desirable results. Resident #13 During an observation on 8/31/2026 at 11:51 AM, Resident #13 was observed with both hands contracted and drawn upward. The fingernails on both hands extended approximately ¼ inch beyond the fingertips and had ragged edges. The fingernails were digging into the palms of the resident’s contracted hands. The palms were moist, and an odor was present. During an observation on 9/1/2026 at 12:14 PM, Resident #13’s fingernails remained long and ragged and continued to dig into the palms of the contracted hands. During an interview on 9/1/2026 at 12:25 PM, Licensed Practical Nurse (LPN) #3 initially stated that all nursing staff were responsible for cutting and filing residents’ fingernails. After consulting another nurse, LPN #3 stated that a body-audit schedule was posted at the nurses’ stations and that nurses were responsible for trimming and filing residents’ fingernails according to the schedule. Review of the schedule revealed Resident #13’s fingernails were scheduled to be trimmed and filed on Saturdays during the 7:00 AM shift. During an observation and interview on 9/1/2026 at	F0677		

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F0677 SS = D	Continued from page 30 3:00 PM, the Director of Nursing (DON) accompanied the State Agency (SA) surveyor to Resident #13's room. The DON observed Resident #13's contracted hands and the long fingernails digging into the palm area. The DON stated, "Oh, those are long. I see where they are digging into her palm there." The DON also confirmed that a slight odor was present in the palm area. The DON stated that nurses were responsible for trimming and filing residents' fingernails during the scheduled body audits. Record review of Resident #13's "Admission Record" revealed Resident #13 was admitted to the facility on 1/18/17 with diagnoses that included type 2 diabetes and dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/26 revealed staff assessed the resident and determined the resident had severe cognitive impairment. Section GG indicated the resident was dependent of staff for all ADLs. Resident #20 During an observation on 8/31/2026 at 12:01 PM, Resident #20 was observed with contracted hands and deformed fingers. The fingernails on both hands were long and ragged. No hand rolls were in use. During an observation on 9/1/2026 at 12:03 PM, Resident #20's hands remained clenched. The fingernails remained long and ragged, and several fingernails were digging into the palms of both hands. During an interview on 9/1/2026 at 2:35 PM, Resident #20's Resident Representative (RR) stated that the resident had previously been able to hold finger foods and feed herself but could no longer do so. The RR stated that Resident #20 had previously used hand rolls to help manage the contractures and prevent the fingernails from digging into her skin. The RR stated that she had not seen staff use the hand rolls for several months. The RR further stated that she had repeatedly informed staff that Resident #20's fingernails needed to be trimmed and filed. According to the RR staff stated that they would address the concern but failed to do so. When the RR lifted Resident #20's hand, the fingernails remained long and jagged, and an odor was present. During an observation and interview on 9/1/2026 at 3:00 PM, the DON observed Resident #20's contracted hands and the long fingernails digging into the palm areas. The DON stated, "Oh my," and	F0677		

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F0677 SS = D	Continued from page 31 informed the RR that staff would trim and file the resident's fingernails. The DON stated that nursing staff were expected to provide care according to each resident's needs, orders, and care-plan interventions. The DON stated that nurses were expected to follow the body-audit schedule for fingernail trimming and filing. The DON also stated that she had conducted several trainings and in-services regarding the issue. Record review of Resident #20's "Admission Record" revealed the resident was admitted to the facility on 10/4/23 with diagnoses that included cerebral palsy and bilateral hand contractures and depended on staff for all activities of daily living care. Record review of the MDS with an ARD of 5/26/26 revealed a BIMS score of three (3) indicating the resident had severe cognitive impairment.	F0677		
F0688 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 observation, staff interview, record review and facility policy review the facility failed to ensure residents who had contractures received appropriate treatment and interventions to prevent a functional decline in range of motion for one (1) of two (2) residents reviewed with contractures. Resident #13.	F0688		

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

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F0688 SS = D	Continued from page 32 Findings include: Record review of the facility policy, “ADL Care of Resident Policy” revealed activities of daily living care was to be provided according to each resident’s individualized needs. The policy further directed staff to provide care specific to the residents’ needs to achieve the most desirable results. During an observation on 08/31/26 at 11:51 AM, Resident #13 was lying in bed. Both of the resident’s hands were contracted and drawn inward. No hand rolls were observed in either hand. During an observation on 09/01/26 at 12:14 PM, Resident #13 was observed with no hand rolls in place. During an interview on 09/01/26 at 3:00 PM, the Director of Nursing (DON) stated she would investigate the absence of the hand rolls and review the therapy recommendations. During an observation on 09/02/26 at 8:40 AM, Resident #13 revealed bilateral hand rolls were in place after the State Agency (SA) had informed the facility. During an interview on 09/03/26 at 11:20 AM, the DON stated hand rolls were supposed to be used for Resident #13. During an interview on 09/03/26 at 3:00 PM, the Director of Rehabilitation/Speech-Language Pathologist (SLP) stated Resident #13’s most recent therapy evaluation was completed on 08/13/26. The SLP stated the resident was dependent upon staff for all activities of daily living and was at baseline for physical, occupational, and speech therapy services. The SLP stated hand rolls were appropriate for Resident #13 to help prevent or limit further decline and worsening of the resident’s contractures. The SLP stated nursing staff did not need an order to initiate the use of hand rolls. The SLP stated therapy staff could train nursing staff on the use of hand rolls and splints and the management of contractures. During an interview on 09/03/26 at 3:23 PM, Licensed Practical Nurse (LPN) #2 and Registered Nurse (RN) #2 stated hand rolls were helpful in preventing further decline and worsening of contractures. Both nurses stated an order was not required, and nursing staff could initiate the use of hand rolls. LPN #2 stated that during her approximately two years of employment at the facility, she had never observed hand rolls in	F0688		

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F0688 SS = D	Continued from page 33 Resident #13's hands. Record review of Resident #13's "Admission Record" revealed diagnoses of hemiplegia and hemiparesis following a cerebral infarction and bilateral lower-extremity contractures. Record review of Resident #13's Minimum Data Set (MDS) with an Assessment Reference Date of 05/26/26 revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. Review of Section GG revealed Resident #13 was dependent upon staff for all activities of daily living	F0688		
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,	F0867		

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F0867 SS = D	Continued from page 34 analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The	F0867		

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F0867 SS = D	Continued from page 35 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, facility policy review and Centers of Medicare and Medicaid Services (CMS) form 2567 review the facility failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to properly secure a wheelchair security device and prevent accidents for residents who depended on the facility van on 2/23/26 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of (11) deficiencies cited. F689. Findings include: Record review of the facility policy "QAPI Plan" undated, revealed, "Purpose: The purpose of the QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents...To do this, employees will participate in ongoing QAPI efforts which support our mission by enabling our residents to live life to its fullest, regardless of age or health, with Compassion, Honest, Accountability and Trustworthiness. Guiding Principles: ...The	F0867		

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F0867 SS = D	Continued from page 36 outcome of QAPI in our organization is to improve the quality of care and the quality of life of our residents..." Record review of the Centers for Medicare and Medicaid Services (CMS) document 2567 dated 2/23/26 revealed the facility was cited F689 for failing to properly secure a wheelchair security device and prevent accidents for residents who depended on the facility van and staff for transfers to medical appoints for one (1) of three (3) sampled residents. Resident #1 Review of the current recertification survey, August 2026 revealed the facility was again cited under F689 for the facility failing to properly secure a wheelchair security device and prevent accidents for residents who depended on the van and staff for transfers to medical appointments for (1) of (19) sampled residents. During an interview with the Administrator on 9/3/26 at 5:33 PM, she acknowledged the facility was cited during a complaint investigation in February 2026 for a fall during transport of Resident #17 and it did happen again for that same Resident on 8/24/26. She indicated she thought the proper protocols were in place and that staff was continuing to follow them. However, due to the repeated incident it seems staff did not continue to follow the processes put in place. The Administrator indicated the importance of continued monitoring is to ensure the Resident remain safe and consistently obtain quality care.	F0867		