

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 09/17/2026	
NAME OF PROVIDER OR SUPPLIER PLEASANT HILLS COMMUNITY LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1600 RAYMOND RD , JACKSON, Mississippi, 39204			
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F0000	<p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #3206646 and CI MS #3191851) at the facility on 9/15/26 through 9/17/26. CI MS #3206646 was investigated related to quality of care and physical environment with no citations. CI MS#3191851 was investigated related to the facility's failure to initiate cardiopulmonary resuscitation (CPR) on a resident who was a full code.</p> <p>On 9/16/26 during the survey, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that occurred on 9/9/26 when Resident #15 was found unresponsive and the code status in the paper chart and electronic medical record (EMR) conflicted. Subsequently, CPR was not initiated and the resident expired.</p> <p>IJ and SQC existed at:</p> <p>42 CFR §483.24(a)(3) Personnel provide basic life support, including CPR -F678- S/S "J"</p> <p>This situation caused Resident #15 serious harm, serious injury, impairment and death and placed other residents in a situation that was likely to cause serious injury, serious harm impairment or death.</p> <p>The SA notified the facility's Administrator of the IJ and SQC on 9/16/26 at 4:30 PM.</p> <p>Based on the implementation of corrective actions on 9/9/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 9/11/26, prior to the SA's entrance on 9/15/26.</p> <p>The facility submitted an acceptable corrective action plan on 9/16/26, in which the facility alleged all corrective actions were completed prior to the SA entrance on 9/15/26. The SA validated through interview, observation, and record review that the corrective actions had been implemented and the IJ was removed prior the SA entrance. Therefore, the noncompliance was determined to be Past Noncompliance.</p> <p>The facility census was 79, and the facility was</p>			F0000			

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000	Continued from page 1 licensed for 100 beds.			F0000			
F0678 SS = SQC-J	<p>Cardio-Pulmonary Resuscitation (CPR)</p> <p>CFR(s): 483.24 (a) (3)</p> <p>\$483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and facility policy review the facility failed to provide basic life support, including Cardiopulmonary Resuscitation (CPR), for one (1) of (1) sampled residents reviewed for CPR and code status. Resident #15. Resident #15 elected Full Code status upon admission on 09/03/26. On 09/09/26, Resident #15 was found unresponsive, without respirations, pulseless, and without detectable vital signs. Licensed nursing staff relied on outdated paper medical record information identifying the resident as Do Not Resuscitate (DNR), failed to immediately verify the resident's current code status in the Electronic Health Record (EHR), and failed to initiate CPR. After staff verified that Resident #15 was Full Code and the Director of Nursing instructed staff to initiate CPR, CPR was not initiated. Resident #15 expired without receiving CPR.</p> <p>The facility's failure to maintain consistent and current code status information, communicate Resident #15's Full Code status to nursing staff, ensure staff knew where to immediately verify current code status, ensure nursing personnel maintained required CPR certification, and initiate CPR when Resident #15 was found unresponsive, pulseless, and not breathing resulted in the resident's expressed choice for CPR and life-sustaining treatment not being honored. The failure resulted in Resident #15 receiving no resuscitative efforts during a cardiopulmonary emergency and created a likelihood for serious injury, serious harm, serious impairment, or death for residents who elected CPR.</p> <p>The situation was determined to constitute Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 09/09/26 when Resident #15 was found unresponsive, pulseless, and not breathing and staff failed to initiate CPR despite the resident's Full Code status.</p>			F0678	"Past Noncompliance - no plan of correction required"		

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F0678 SS = SQC-J	<p>Continued from page 2</p> <p>On 09/16/26 at 4:30 PM, the State Agency (SA) notified the Administrator of the IJ and SQC and provided an IJ Template.</p> <p>The IJ and SQC existed at:</p> <p>42 CFR §483.24(a)(3) Personnel provide basic life support, including CPR (F0687) Scope and Severity (S/S) - J</p> <p>The facility submitted an acceptable corrective action plan on 09/16/26, in which the facility alleged all corrective actions were necessary to remove the IJ were completed on 09/10/26 and that the IJ was removed on 09/11/26, prior to the SA's entry on 09/15/26. The SA validated through interview, observation, and record review that the corrective actions had been implemented and the IJ was removed prior to SA entrance. Therefore, the noncompliance was determined to be Past Noncompliance (PNC).</p> <p>Findings Included:</p> <p>Record review of the facility policy review, "CARDIOPULMONARY RESUSCITATION", Current Revision Date 11/20/16, revealed the policy stated, "Personnel that have completed training will provide Cardiopulmonary Resuscitation (CPR)/Basic Life Support (BLS) to victims of sudden cardiac arrest. Facility staff will provide CPR prior to the arrival of emergency services in accordance with the resident's advance directives...EMERGENCY PROCEDURE...3. Begin CPR if the adult victim is unresponsive and not breathing without checking the victim's pulse...4. Following initial evaluation, begin CPR with chest compressions rather than opening the airway and delivering rescue breathing...5. All rescuers should provide chest compressions to victims of cardiac arrest."</p> <p>Record review of the "Admission Record" for Resident #15 revealed the facility admitted him on 9/03/26 with diagnoses that included heart failure, atrial fibrillation and peripheral vascular diseases.</p> <p>Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/09/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment.</p> <p>Record review of the Code Status form dated 9/03/26 and electronically signed by Resident #15 revealed he chose Cardiopulmonary Resuscitation (CPR).</p>			F0678			

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F0678 SS = SQC-J	<p>Continued from page 3</p> <p>Record review of the "Order Summary Report" with active orders as of 9/17/26 revealed an order dated 9/3/26 "Full Code."</p> <p>Record review of the "Progress Note" dated 9/09/26 revealed Licensed Practical Nurse (LPN) #5 documented "Called to resident room per Certified Nursing Assistant (CNA) at approx. (approximately) 0535 (5:35 AM) upon entering room noted resident lying supine position in bed eyes closed skin warm to touch no resp (respirations) or V/S (vital signs) noted called assist from long hall nurse resident chart checked and confirmed code status DNR."</p> <p>On 9/15/26 at 3:00 PM, interview with LPN #5 revealed that he held no current CPR certification on 9/09/26. He said that he had not received in-service training regarding CPR or where to locate resident's code status at the facility. He said that to the best of his knowledge and according to previous experience, resident code status was located on each resident's paper chart on the first page of the chart. He stated that he was summoned to the room of Resident #15 at approximately 4:45 AM on 9/09/26 by CNA #6 and CNA #7 who reported the resident was unresponsive. He said he assessed Resident #15 and confirmed that he was nonresponsive, was not breathing, and was pulseless with no detectable vital signs. He said that he and LPN #4 checked Resident #15's paper chart at the nurses' station and on the first page there was an orange sticker that stated, "Do Not Resuscitate." He said that he also checked the physician orders on the paper chart and there was an order that stated, "Do Not Resuscitate". He said that LPN #4 made telephone notifications and when she called the Director of Nurses (DON), approximately 10 to15 minutes later they were made aware that the correct locations of the current code status for each resident was in the EHR and that Resident #15 was a Full Code since his 9/03/26 admission. He stated that he did not initiate CPR because there had been too long since the resident was observed without signs of life and he considered it a futile exercise and undignified treatment of the resident. He stated the conflict between the code status in the paper chart and in the EHR was the problem. He confirmed that his employment had been suspended pending investigation on 9/10/26 and he was notified on 9/15/26 that his employment at the facility had been terminated.</p> <p>On 9/16/26 at 11:00 AM, during a telephone interview, LPN #4 said on 9/09/26 at approximately 4:45 AM, CNA #6 and CNA #7 reported Resident #15</p>			F0678			

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F0678 SS = SQC-J	<p>Continued from page 4</p> <p>was not responsive. She said she and LPN #5 assessed Resident #15 and he was not breathing, pulseless with no detectable vital signs. They both checked the paper chart at the nurse's station for his code status and on the first page and there was an orange "Do Not Resuscitate" sticker. They checked the physician's orders and located a "Do Not Resuscitate" order which was undated. She stated she began making notifications and when she called the DON at 5:40 AM on 9/09/26, the DON asked if they had initiated CPR and that the correct location of resident code status was the EHR. She said she checked the EHR of Resident #15 and discovered his code status was "Full Code." She said she told LPN #5 but neither of them initiated CPR.</p> <p>On 9/17/26 at 2:15 PM, interview with the Director of Nurses (DON) revealed Resident #15 had advanced directives in place on 9/09/26 which were not honored because, "He wanted CPR." She explained that the resident had once chosen "Do Not Resuscitate (DNR)" code status, as indicated in his paper chart which had not been updated following his most recent admission on 9/03/26. She confirmed that the nurse's job description included being CPR certified but said she was not sure if all were. She confirmed that when notified on 9/09/26 at 5:40 AM by LPN #4 that the resident was unresponsive, pulseless and not breathing and that there was a discrepancy between his code status in his paper chart and in his electronic health record (EHR), she had instructed nursing staff on duty to initiate CPR in accordance with the residents' choice and physician's orders, but no CPR had been initiated.</p> <p>On 9/17/26 at 2:35 PM, during telephone interview with CNA #6 said that between 1:00 AM and 2:00 AM she and CNA #7 went in during rounds and that they peeked in and did not go in and do incontinence care or repositioning. She stated that when they went in at 4:00 something she called his name and he didn't respond. She said they were not aware of his code status and immediately notified LPN #4 and LPN #5.</p> <p>On 9/17/26 at 3:17 PM, interview with Admission Coordinator revealed when she met with Resident #15 upon his return to the facility on 9/03/26 and he wanted CPR if he suffered a cardiac event that left him pulseless and not breathing.</p> <p>On 9/17/26 at 3:28 PM interview with Human Resources Director (HR) revealed that nurses were expected to maintain a current CPR certification</p>			F0678			

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F0678 SS = SQC-J	<p>Continued from page 5 according to their job description.</p> <p>Record review of the facility reported incident report revealed on 9/9/2026 at or around 4:45 AM-4:50 AM, CNA #6 and CNA #7 were making their last rounds before the end of the shift. CNA #6 called Resident #15's name, he did not answer. She nudged his shoulder; he did not move. CNA #7 entered the room and CNA #6 stated "he is gone, go get his (Proper name of LPN #5)." CNA #7 went to LPN #5 and stated that she didn't know if he was full code or not, but "we need to know." LPN #5 told CNA #7 to ask LPN #4 what his code status was. LPN #4 pulled his paper chart and stated that Resident #15 was a Do Not Resuscitate (DNR). LPN #4 stated that she remembered a conversation between Registered Nurse (RN) #3 and herself about Resident's #15's code status. RN #3 was informing her that Resident #15's code status had changed from DNR to a Full code. LPN #4 stated that she then checked the EHR to verify that Resident #15 was a full code. LPN #4 then called the Director of Nursing (DON) to inform her of Resident #15's condition and the conflicting code status. The DON told LPN #4 to tell LPN #5 to start a code. LPN #4 called the DON back and stated that LPN #5 stated that "he wasn't touching that, based on the order in the chart". No CPR was performed. The DON then notified the Administrator of the incident.</p> <p>Record review of the Facility Investigation dated 9/12/26 revealed on 9/09/26 at approximately 4:45 PM, CNAs were making rounds and observed Resident #15 nonresponsive, notified LPN #5 and LPN #4 who checked the paper chart which indicated the resident's code status was Do Not Resuscitate (DNR). The current code status, "Full Code" was identified upon review of the resident's current orders in the electronic health record (EHR).</p> <p>Record review of the statement provided by CNA #7 dated 9/09/26 at 2:19 PM, revealed she and CNA #6 observed no problem with Resident #15 on 9/09/26 at approximately 1:45 AM. When they entered his room later while making "last rounds" the resident was nonresponsive and they notified LPN #5. She confirmed that she was not aware of the resident's code status and that no CPR was initiated for Resident #1. Timeline of Events: 9/9/26 at 10:19 AM, All staff in-services began on "Residents Rights to Quality-of-Life", "Self-determination Policy and Procedure", "Emergency Response", The Election of Code Status", "Chain of Command", and "Abuse and Neglect Policy and Procedure". Nursing in-services began on "Advance Directives Policy and Procedure", "Care Plan Policy and Procedure",</p>			F0678			

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F0678 SS = SQC-J	<p>Continued from page 6</p> <p>"Cardiopulmonary Resuscitation (CPR)", "Following Physician Orders" and "Where to Locate Resident Code Status". In-services were conducted by Registered Nurse (RN) Supervisor, Certified Nursing Assistant (CNA) Supervisor, Staff Development, and the Administrator. In-services were completed on 9/10/26.</p> <p>9/9/26 at 10:30 AM, All paper charts and crash cart binders were removed by the Medical Records Clerk.</p> <p>9/9/26 at 11:09 AM, the medical records clerk and the medical records Licensed Practical Nurse (LPN), did a 100% audit on all residents' code status in the Electronic Health Record (EHR). No issues found.</p> <p>9/9/26 at 11:25 AM, The Administrator reported to the State agency. LPN #5 was notified via voice mail that he is suspended pending investigation by the DON.</p> <p>9/9/26 at 11:50 AM, the Medical Director, was notified of incident and emergency Quality Assurance and Performance Improvement (EQAPI)</p> <p>9/9/26 at 12:00 PM, EQAPI meeting was held with the Executive team by the Administrator, to discuss all interventions put in place. The QAPI committee reviewed the incident and actions were taken. The policy on Advance Directives was reviewed with no recommendations for change. The QAPI team determined at this time to prevent further adverse events the interventions would include removing all paper charts from the nurses' station and the code status documents from the crash cart. Person-centered in-services were done with all nursing staff using the electronic health records (EHR) and EHR will be the only source used to obtain resident information. Person-centered in-services were also done with all nurses following the care plan, following physician orders, advanced directives and CPR. Person centered in-services were done with all staff on resident's rights and quality of life, abuse and neglect, and CNAs were in-serviced on emergency response, code status and chain of command. A 100% audit was done on resident advanced directives. A 100 % audit was completed on all resident code status being care planned. A 100 % audit was completed on assuring that all resident code statuses have a physician's order. These interventions are as follows: Daily for 7 days the DON will review residents with new or changed code status orders. weekly for 4 weeks, the DON will audit a sample of residents to verify that the EHR, physician orders, advance directives, and care plans contain consistent code status</p>			F0678			

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F0678 SS = SQC-J	<p>Continued from page 7 information monthly for 3 months. The Director of Nursing (DON) will continue random code status audits to ensure sustained compliance. Any discrepancy identified will be corrected immediately, the cause of the discrepancy will be investigated, and responsible staff will receive immediate education. All audit findings will be reported to the QAPI committee for review and determination whether additional interventions or continued monitoring is necessary.</p> <p>9/9/26 at 1:51 PM, The Administrator filed a report with the Mississippi State Board of Nursing.</p> <p>9/9/26 at 4:44 PM, The staffing Coordinator informed the Administrator that RN #2 agreed to provide CPR classes to all staff. Class dates are 9/20/26, 9/27/26 ,10/18/26 and 10/25/26.</p> <p>9/10/26 at 2:00 PM, The Administrator held a follow-up QAPI meeting with the executive committee to verify that each intervention has been completed.</p> <p>9/11/26 at 8:46 AM, The incident was reported to the Attorney General's Office.</p> <p>The root cause analysis determined by the Administrator and DON found that a failure in the facility's code status reconciliation and process following a change in resident #15's code status. Although the resident #1's current code status had been entered into the EHR, the corresponding paper documentation was not simultaneously updated or removed. This resulted in conflicting code status information being available during an emergency.</p> <p>The facility alleges that all corrective actions were completed to remove the IJ on 9/10/26, and Immediate Jeopardy was removed on 9/11/26, prior to State Agency's entry on 9/15/26.</p> <p>The SA validated on 9/15/26 through 9/17/26 through interview and record review, that all corrective actions had been implemented as of 9/13/26 and the facility was in compliance, prior to the SA's entrance on 9/15/26.</p>			F0678			