STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255112	A. Building B. Wing	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hills Com LIV Center	1600 Raymond Rd Jackson, MS 39204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 37415 Based on observations, staff and family interviews, record reviews, and facility policy review, the facility failed to honor the resident's rights for visitation as evidenced by limiting visitation times and days, not allowing visitation on weekends and not allowing for privacy during the visitation with family for three (3) of five (5) families interviewed. Resident #14, Resident #19, Resident #34. Findings include: 43283 Record review of the facility's Visitation Plan with no date on the policy revealed, it is the policy of this facility to provide visitation for our residents and their families in a safe environment while maintaining infection prevention and control in accordance with federal, state, and local regulations, and guidelines. The policy breaks down guidelines for visitation and the types of visitations including Outdoor Visitation and Indoor Visitation. The policy stated, visitations will be scheduled through the Life Connections Coordinator and/or the Social Director ahead of time and limited to 45 minutes each with no more than 2 visitors per resident during the hours of 8am-5pm. The policy explained several requirements for visitors including prior to visiting with residents, visitors will be screened to recent exposure to COVID-19, any symptoms of COVID-19, must not visit within 14 stays of previously positive test, temperature will be taken, mask must be applied prior to entering screening area, and staff will review visitation procedure with visitors. Record review of the facility's COVID-19 Guidelines policy with revised date of 06/06/2021, revealed, this facility follows federal, state, and local regulations and laws as well as Centers of Disease Control guidance related to COVID-19. The policy stated, visitations will be scheduled through the Life Connections Coordinator and/or the Social Services Director and visitation is observed visually by staff for safety and that no physical contact occurs, and the guidelines are being followed. Record review of the (Proper Name of County) Weekly COVID-19 Snapshot for week ending July 10, 2021, revealed the county positivity rate was less than 10 percent (%) at 9.1%. Resident #14 (continued on next page)

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 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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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #14's Admission Record revealed the facility initially admitted Resident #14 on 02/08/2018 with the diagnoses of High Blood pressure, history of falling, Dementia, Alzheimer's, Muscle wasting and atrophy 04/17/2020, and COVID-19 01/19/2021. Record review for Resident #14's immunizations records revealed Influenza vaccine received on 10/22/2020, Severe Acute Respiratory Syndrome (SARS) COVID-19 vaccine completed on 02/11/2021, and family refused Pneumovax vaccine. On 07/06/21 at 02:30 PM, State Survey Agency (SSA) spoke with Responsible Party (RP) for Resident #1, he explained he was told by the facility he would not be able to come back in the building to see the resident without taking a COVID-19 test. He explained he would love to come back to see his brother because he would come daily to feed his brother and bring him extra food before COVID-19. He explained he does not want to be tested every time he wants to come see his brother, but if he only had to wear a mask, he would come back to see his brother. He further explained Resident #14 has had the COVID-19 vaccines and influenza vaccine. Resident #34 Record review of Resident #34's Admission Sheet revealed the facility admitted Resident #34 on 10/18/2017 with diagnoses of Diabetes Mellitus, Deficiency of Vitamins, Dysphagia, Dementia, and Gastrostomy status. Record review the Resident #34's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/12/2021 section C revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Record review of Resident #34's immunization record revealed Resident #34 completed COVID-19 vaccines on 03/04/21. On 07/06/21 at 04:24 PM, SSA spoke to RP, resident's son, for Resident #34, he denied any problems with the care his mom is receiving at the facility. He reported he only gets to come see his mom once a week and will be here this week. He explained he would come more often if he could and that he does get tested for COVID-19 at each visit. He reported his mom has had been vaccinated for COVID-19 and has no roommate. Resident #19 During an interview on 07/08/21 at 09:09 AM, Resident #19's daughter complained the facility only let her visit once a week. The daughter also said the facility would let her visit for an hour. The daughter also complained of having to be COVID-19 tested with every visit. Review of Resident #19's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/29/21, revealed Resident #19 had a Brief Interview of Mental Status (BIMS) score of 2, which indicated the resident is cognitively impaired. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/07/2021 at 2:20 PM SSA observed Social Services Director (SSD) testing two (2) visitors for COVID-19. She explained all visitors are informed if they come visit their family member, they would be testing for COVID-19. She further explained the visitation is done in the waiting area outside of her office in the wide-open room. The room has several chairs for the visitors and the resident sits six (6) feet apart in their wheelchair. She explained she must supervise all visitations to ensure that guidelines are followed. She reported no visitors have been allowed to go to the resident's room even if the resident is in a private room. She reports each visitation is scheduled through her and there are some visits on the weekend when someone is available to supervise the visit. During an interview on 07/08/21 at 09:09 AM with Social Services Director (SSD) confirmed the resident ' s family has to schedule an appointment for visits if there in a private room or shared room. The SSD said the family can only visit in the designated area of the building or the outside patio. The family has to be COVID-19 tested prior to visitation during each visit. The family can only visit twice a week. The SSD also said the family cannot visit on weekends because the facility doesn't have anybody working to monitor the visits. On 07/09/2021 at 3:30 PM, during an interview with the SSD, she explained she was just updated today at 02:00 PM regarding the visitation guidelines explaining visitors do not have to be tested . She explained a visitor was here for visitation and was informed when they arrived no further testing. She reported she plans to call families and inform them of the new guidelines and will send out a letter on Monday to all families regarding the change. During an interview on 07/09/21 at 03:33 PM, with the Administrator confirmed the facility scheduled visits during the week. The visitors could only visit twice a week and must be monitored by the SSD. The Administrator confirmed all visitors must be COVID-19 tested prior to visiting the residents. The visitors are not allowed to visit on weekends because the SSD is off. The Administrator also confirmed COVID-19 testing the visitors is not in the facility policy. The Administrator said she doesn't know why the facility is COVID-19 testing the visitors.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37415 Based on observation, staff interviews, record reviews and facility policy review the facility failed to follow the comprehensive care plan by not providing pain medication prior to wound care and not securing a foley catheter strap to the leg for two (2) of six (6) care plans reviewed, Resident #19. Findings Include: Record review of the facility's Comprehensive Care Plans date?policy revealed it is the policy of this facility to develop and implement a comprehensive person- centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Record review of the facility's Comprehensive Care Plan, revised 03/01/21, revealed Resident #19 has an indwelling catheter related to pressure ulcer on her sacrum. Resident #19 is at risk for complications associated with indwelling catheter, such as infections, trauma. Interventions: staff to secure the catheter tube so you do not pull or move the catheter. Record review of the facility's Comprehensive Care Plan, revised 1/21/21, revealed the focus, I am at risk for pain r/t (related to) pressure injury/ulcer . The interventions reveal to Administer medications as per orders; and anticipate my need for pain relief and respond to any complaint of pain. During an observation on 07/08/21 at 09:24 AM, of catheter care with Certified Nursing Assistant (CNA) #1 revealed Resident #19's foley catheter leg strap was not secured to the leg. The tubing was connected to the bed frame and was tight, tugging on the meatus. Observation on 07/08/21 at 02:18 PM, of wound care to the sacrum, right buttocks and left buttocks revealed Resident #19's wounds were debrided by the wound doctor. During the debridement, the resident continued with a low constant moan. The State Survey Agency (SSA) asked if the resident received anyting for pain prior to debridement. Licensed Practical Nurse (LPN) #3 said yes, the residents are medicated prior to wound care every Thursday. Observation of the resident's foley catheter strap not secured to the leg. The glue to the strap was gone and would not stick. The tubing was connected to the bed frame. The tubing was tight, tugging on the meatus. Interview on 07/08/21 at 02:20 PM with LPN #3 said the floor nurses are responsible for medicating the residents every Thursday when the Wound Doctor visit. LPN #3 also confirmed during wound care the resident's catheter strap was not secured to the leg. The glue on the strap would not stick to the leg. LPN #3 said the CNA and floor nurse that is assigned to the resident should have changed the strap. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 07/08/21 at 02:30 PM, record review of the facility's Medication Administration Record (MAR) with LPN #3 revealed that on 7/8/21 the resident did not receive pain medication prior to the doctor debriding the resident's wounds. During an interview on 07/08/21 at 02:30 PM, with LPN #3, she said reminded the floor nurse that the Wound Doctor was coming today and to make sure the residents were medicated. LPN 3 confirmed Resident #19 was not medicated prior to the doctor debriding the wound on 7/8/21. LPN #3 said she did not know why the floor nurse did not medicate Resident #19. In an interview on 07/08/21 at 02:31 PM, with LPN #4 confirmed she failed to follow the care plan by not medicating Resident #19 prior to wound care and not securing the residents catheter strap to her leg. On 07/08/21 at 02:45 PM, during an interview with the Interim Director of Nursing (IDON) revealed the floor nurses were recently in-serviceed on providing pain medication prior to wound care. The DON confirmed the staff did not follow the care plan by not medicating th resident and securing the catheter strap. The DON said this caused the resident unnecessary pain by not giving her medication for pain prior to debriding the wound. During an interview on 07/8/21 at 03:58 PM, with LPN #5, Minimum Data Set/Care Plan Nurse, revealed she expected the staff to follow the care plan. LPN #5 said LPN # 4 should have medicated the resident before the doctor debrided her wounds and when the resident is in pain. The staff should anticipate the residents pain because she cannot tell the staff when she is in pain. LPN #5 also said she expect the facility to follow the care plan by securing the residents catheter to prevent trauma or infection.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37415 Based on observation, staff interviews, record review and facility policy review the facility failed to secure the urinary catheter to the resident's thigh for one (1) of six (6) urinary catheters reviewed. Resident #19. Findings include: Review of the facility's Catheter Care, Urinary policy, dated August 25, 2014, revealed the purpose of this procedure is to prevent catheter-associated urinary tract infections. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: catheter tubing should be strapped to the resident's inner thigh.) Review of the facility's Comprehensive Care plan, date initiated 07/25/2018 revealed Resident #19 had an indwelling catheter related to pressure ulcer on sacrum. Resident is at risk for complications associated with indwelling catheter such as infection and trauma. The intervention initiated on 03/01/1021 was to secure the catheter tube so you do not pull or move the catheter. During an observation on 07/08/2021 at 09:24 AM of catheter care with Certified Nursing Assistant (CNA) #1 revealed Resident #19's foley catheter leg strap was not secured to the leg. The foley catheter tubing was connected to the bed frame and was tight, tugging on the meatus. During an observation on 07/08/2021 at 02:18 PM, of wound care to the sacrum, right buttocks and left buttocks revealed Resident #19's foley catheter strap was not secured to the leg. The glue to the strap was gone and would not stick to the resident's leg. The foley catheter tubing was connected to the bed frame. The tubing was tight, tugging the meatus. During an interview on 07/08/21 at 02:20 PM, License Practical Nurse (LPN) #3 confirmed during wound care the resident's catheter strap was not secured to the leg. The glue on the strap would not stick to the leg. LPN #3 said the CNA and floor nurse that is assigned to the resident should have changed the strap. Interview on 7/8/2021 at 2:30 PM, with CNA #1 confirmed she did not tell the nurse Resident #19's leg strap was not secured to her leg. CNA #1 said she got busy and forgot. CNA #1 confirmed this could cause trauma to the meatus and/or infection. During an interview on 7/8/21 at 2:30 PM, with LPN #4 revealed she was not told the catheter strap was not secured to the resident's leg. LPN #4 said the CNAs did not report this to her. LPN #4 said she did not notice it when she was in the resident's room. LPN #4 confirmed this could cause trauma to the meatus and could cause infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/08/21 at 02:45 PM, with the Interim Director of Nursing (IDON) confirmed the floor nurse and the CNAs are responsible for making sure the catheter straps are secured to the residents leg to prevent trauma to the meatus and can cause infections. The DON said she is the interim DON. She did not know if the staff had been trained to make sure the catheter strap was secured to the residents leg. A review of Resident #19's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/29/21, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident is severely cognitively impaired.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415 Based on observation, interviews, record reviews and facility policy review the facility failed to check placement for one (1) of five (5) residents observed for Percutaneous Endoscopic Gastrostomy (peg) tube medication administration. Resident #33. Findings include: A review of the facility's policy, Gastrostomy Tube, Confirming Placement, dated 8/25/2014, noted the purpose of this procedure is to ensure proper placement of the gastrostomy tube to prevent aspiration. The policy revealed attach 50 to 60 milliliter (ml) syringe containing approximately 10 cubic centimeters (cc) of air. Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing and listen for whooshing sound to check placement of the tube in the stomach. On 07/08/21 09:10 AM, an observation and interview of LPN #2 during medication pass for Resident #33, revealed LPN #2 administered medication via peg tube. LPN#2 did not check placement of peg tube by aspiration/auscultation before administering medication. LPN #2 stated she usually checks placement to make sure the peg tube is in the right place. She stated that by not checking placement it can cause the resident to get an infection. She also stated that a resident can get pneumonia and die from aspiration if placement is not checked prior to administrating medication. She stated it slipped her mind and she forgot to check placement. She stated she usually checks placement. On 7/9/21 at 4:05 PM, in an interview the Interim Director of Nursing (IDON) stated LPN #2 could have caused the resident harm. She stated nurses should always check placement before administering medication via peg tube. The medication could go in other places in the body, like the lungs and cause harm to the resident. Record review of Resident #33's Admission Record revealed an admitted [DATE] with medical diagnoses of Dysphasia, Oropharyngeal Phase, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right Dominant side and Gastro-Esophageal Reflux Disease without Esophagitis. Record review of the Order Summary Report revealed an order dated 6/21/21 to check placement of peg tube via aspiration/auscultation before administering flushes, bolus feedings or medication every shift. Record review of the Minimum Data Set with an Assessment Reference Date of 6/12/21, revealed Section K is coded for abdominal PEG tube.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37415 Based on observation, staff interviews, record reviews and facility policy review the facility failed to administer pain medication prior to the surgical debridement of wounds resulting in the resident experiencing pain for one (1) of six (6) wound care observations. Resident #19. Findings Include: Review of the facility's Pain Management policy, dated January 31, 2005 revealed: Every resident has the right to be as comfortable and pain free as possible. The facility has an ongoing commitment to pain recognition and management. Pain control is essential to the continued quality and dignity of life as well as the maintenance of each resident's current level of function. The licensed nurse will screen the resident for pain a.) on admission/readmission, b.) with each quarterly, annual and or significant change of the Minimum Data Set (MDS) assessment and c) as needed with condition change. The resident's attending physician will be informed when appropriate, and orders for analgesia will be obtained to promote resident comfort. Pain intensity will be measured with appropriate measurement tool. A pain scale do 0-10 (0=no pain, 10- worst pain) will be utilized for adult patient. If the resident cannot understand or is unwilling to use the scale, the following tools may be utilized such as, face pain scale (smile-frown) and residents change in behavior will be assessed. Any resident who request an as needed (PRN) pain medication will have their pain assessed using a scale 1-10 and recorded on the Medication Administration Record (MAR). Reassessment of the resident's pain will be performed within 1 hour after any PRN method of pain relief is used to determine the effectiveness pf the method. The assessment will be recorded on the PRN Medication Administration Record. Record review of the facility's Order Summary Report dated July 8, 2021 revealed the resident is ordered Acetaminophen 325 milligrams (mg) via peg (percutaneous endoscopic gastrostomy) tube every 4 hours (pain), Norco 5-325 mg (Hydrocodone/Acetaminophen) give one tablet via peg tube every 6 hours as needed (pain). Record review of the facility's MDS Pain interview, dated 6/25/21, 4/28/21, 4/19/21, 3/30/21 and 1/18/21 revealed Resident #19 was assessed for pain and pain was identified on each evaluation. During an observation on 07/08/21 at 02:18 PM, of Resident #19 wound care to the sacrum, right buttocks and left buttocks revealed License Practical Nurse (LPN) #3 removed the bandage. The Wound Doctor measured the wound to the sacrum, stage 4. measured at 6.5 centimeters (cm) length x 4.5 cm width x 4. 7cm depth. The wound bed had 25 percent of yellow slough. The Wound Doctor debrided the wound. Resident #19 noted with a constant low moan. The State Survey Agency (SSA) ask if the resident was medicated prior to treatment. LPN #3 said yes, Resident #19 was medicated prior to treatment. LPN #3 cleansed the wound with wound cleanser, applied calcium alginate with silver and covered with border gauze. Resident #19 continued with a constant low moan. The doctor measured the left buttocks at 6.5 cm length x 5.4 cm width x 0.1 cm depth and debrided the wound. Resident #19 continued with constant low moan. LPN #3 cleansed the wound with wound cleanser, applied Santyl to eschar and covered the wound with bordered gauze. The Wound Doctor measured the right buttocks at 6.5 cm length x 5 cm width x 0.1 cm depth and debrided the wound. LPN #3 cleansed the wound with normal saline, applied santyl to the eschar and covered with border gauze. Resident #19 continued with a constant low moan. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During 07/08/21 02:20 PM, interview with LPN #3 said the floor nurses are responsible for medicating the residents every Thursday when the wound doctor visit. Record review of the facility's Medication Administration Record (MAR) for 7/8/21 with LPN #3 after Resident #19's wound care revealed Resident #19 did not receive pain medication prior to the doctor debriding the residents wounds. Record Review of the facility's Controlled Drug Receipt/Record/Disposition (narcotic log) form revealed Resident #19's Hydrocodone/Acetaminophen 5-325 mg was signed out 7/8/21 at 15:10 (3:10 PM) after the resident wounds were debrided. Record review of the July 2021 MAR from July 1 through July 8 revealed Resident #19 experienced pain at an intesity of 8-10 on a scale of 1-10 for three (3) of the eight (8) days reviewed, requiring the adminstration of Norco 5-325 mg. Record review of the facility's Nurses Notes, dated 7/2/21 revealed Resident #19's wounds were debrided by the Wound Doctor. Review of the MAR and Narcotic Log revealed Resident #19 did not receive pain medication before the doctor debrided the wound on 7/2/21. Interview on 7/8/21 at 2:30 PM, with LPN #3 revealed she went in and talked to Resident #19. LPN #3 informed the resident that the doctor would be coming in today to look at her wounds and the bandages would be changed. The nurse asked the resident if she needed something for pain. The resident said yes. LPN #3 said she remind LPN #4 the doctor was coming today to look at the resident's wound. LPN #3 ask LPN #4 to give Resident #19 something for pain prior to wound care. LPN #3 confirmed Resident #19 was not medicated prior to the doctor debriding the wound. LPN #3 said she doesn't know why LPN #4 did not medicate Resident #19. During an interview on 07/08/21 at 02:31PM, with LPN #4 revealed she was responsible for medicating Resident #19 prior to the wound doctor providing wound care. LPN #4 confirmed she got busy and forgot to give Resident #19 pain medication prior to wound care. LPN #4 said she did not know the doctor was debriding the resident today. LPN #4 said she needed to communicate better with the wound doctor and nurse. LPN #4 confirmed because Resident #19 did not receive pain medication caused the resident unnecessary pain when the Wound Doctor debrided the wounds. During an interview on 07/08/21 at 02:45 PM, with the Interim Director of Nursing (IDON), the IDON said the floor nurses were recently in-serviced on providing pain medication prior to wound care. The IDON said LPN #4 was not present for this in-service. The IDON confirmed this caused Resident #19 unnecessary pain by not giving her pain medication prior to debriding the wound. A review of Resident #19's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/29/21, revealed Resident #19 had a Brief Interview of Mental Status (BIMS) score of 2, which indicated the resident is severely cognitively impaired.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observations, staff and resident interviews, record reviews, and facility policy review, the facility failed to ensure a less than five percent medication error rate for two (2) of 34 medication opportunities. Resident #7 and Resident #222. Findings include: A review of the facility's policy, Oral Inhalation Administration, dated 11/01/2008, revealed, Purpose: To allow for correct administration of oral inhalers to residents .L. Have resident rinse his/her mouth and spit out the rinse water. Resident #222 On 7/7/21 at 10:10 AM, an observation of License Practical Nurse #1 (LPN) of a medication pass to Resident #222 revealed, LPN #1 gave Resident #222 Budesonide-Formoterol Fumarate Aerosol 160-4.5 MCG/ACT (micrograms/actuation). LPN #1 did not offer Resident #222 water to rinse his mouth after inhaler usage. On 7/8/21 at 11:10 AM, in an interview with LPN #1, he stated that the purpose of the resident rinsing the mouth out is due to after taste of inhalers usage. He then stated that he guessed it can cause a breakdown in the resident's mouth. He stated that he forgot to give the resident water to rinse his mouth after inhaler usage. He stated he always offers residents water to rinse out their mouth after inhaler usage. On 7/8/21 at 1:25 PM, in an interview with Resident #222, he stated the nurses usually give him water to rinse his mouth after he uses his inhalers. He denied any problems in his mouth after inhaler usage on 7/7/21. Record review of Resident #222 Admission Record revealed an admitted [DATE] with medical diagnoses of Shortness of Breath, Hypertension, and Atelectasis. A record review of the Order Summary Report revealed, Budesonide-Formoterol Fumarate Aerosol 160-4.5 MCG/ACT 2 puffs inhale orally two times a day related to Shortness of Breath, rinse mouth after use. Review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/28/21, for Resident #222 Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates the resident is cognitively intact. Resident #7 On 7/8/21 at 8:48 AM, during an observation of LPN #2's medication pass to Resident #7, LPN #2 gave Resident #7 Symbicort Aerosol 160-4.5 MCG/ACT 2 puffs inhaled orally BID and . LPN #2 did not give the resident water to rinse mouth out after usage. (continued on next page)

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	255112	A. Building B. Wing	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hills Com LIV Center	1600 Raymond Rd Jackson, MS 39204

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/8/21 at 11:40 AM, in an interview with LPN #2, she stated she forgot to have the resident rinse her mouth out. She stated that if a resident does not rinse the mouth out, a resident can get an infection. She later stated that a resident can get yeast on their tongue from not rinsing the mouth out. She stated it slipped her mind, that she usually does get the resident to rinse out her mouth after inhaler usage. On 7/9/21 at 4:05 PM, in an interview with the Interim Director of Nursing (IDON), she stated the nurses should offer residents water to rinse their mouths out after a steroid inhaler usage. She stated it can cause yeast to build up and cause dryness in the mouth which could possibly lead to infection. On 7/9/21 at 4:35 PM, in an interview, Resident #7 stated the nurses do not give me water to rinse my mouth out. She stated they gave her water today to rinse her mouth out. She stated they have never given her water to rinse her mouth out before today. Review of Resident #7 Admission Record revealed an admitted [DATE] and diagnoses of Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Type 2 Diabetes Mellitus with Diabetic Nephropathy. A review of Resident #7 Order Summary Report revealed an order for Symbicort Aerosol 160-4.5 MCG/ACT 2 puffs inhale orally two times a day related to COPD with Acute Exacerbation. Rinse mouth after using. Review of the Minimum Data Set (MDS) with Assessment Reference Date of 6/28/21, for Resident #7 Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates the resident is cognitively intact. Record review of Resident #7's Consultant Pharmcist Communication to Nursing dated 5/30/21 revealed , RE: Symbicort- add rinse mouth after use. Please make sure that following each administration of this med that the patient rinses their oral cavity (and spits). This agent can decrease cell-mediated immunity leading to an overgrowth of candida-yeast. (If prolonged contact with oral cavity/throat.) Thanks. This report was signed by the nurse on 6/3/21.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43283 Based on observation, staff interviews, record reviews and facility policy review, the facility failed to prevent the possible spread of infection by taking wound supplies from one residents room to another, failed to remove discarded supplies from the resident's room, failed to clean scissors between resident's, failed to clean the bedside table or use a barrier for set up of wound care supplies and returned unused wound supplies from resident's rooms to the medication cart for two (2) of five (5) residents observed for Percutaneous Endoscopic Gastrostomy (PEG) tube dressing change. Resident #1 and Resident #34. Findings include: Record review of the facility's policy Wound Care Infection Prevention Guidelines, dated June 6, 2013, revealed, PURPOSE: To minimize the potential for infection in wound care. GUIDELINES: .III. Supplies should be place on a clean surface .VIII. Trash is bagged in the room and again in the bag on the cart. This bag is disposed in the soiled utility room. Record review of the facility's policy INFECTION PREVENTION/PROCEDURE FOR MAJOR WOUNDS, dated June 6, 2013, revealed, PURPOSE: To provide guidelines for good infection prevention technique in wound care .II. PROCEDURE: . C. Set up the supplies on a CLEAN surface at the bedside (cover the surface with a clean impervious barrier before putting the supplies out) G. Cut the tape with your clean scissors I. Remove the soiled dressing and place in a bag at the bedside. Place the soiled scissors on a separate barrier .K. Clean the scissors with 60 second contact with alcohol and place on a CLEAN corner of your setup .O. Place soiled gauze used for cleaning in the bag .S. Remove gloves and place in bag. T. Initial, date and time dressing .V. Close the bag and place in the large plastic bag attached to the cart . On 07/08/21 at 09:10 AM, State Survey Agency (SSA) observed Licensed Practical Nurse (LPN) #3 gather supplies for wound care at the nurse's station. She cleaned the scissors with micro-kill bleach wipes and placed them on Kleenex and then took the scissors wrapped in Kleenex and supplies to Resident #34's room. LPN #3 did not clean the bedside table or place a barrier on the table before placing the supplies on table. The new dressing applied to Percutaneous Endoscopic Gastrostomy (PEG) tube site was not labeled, dated, or initialed. LPN #3 placed the old dressing, soiled gauzes, and all gloves from the wound care in the garbage can in Resident #34's room and did not remove the bag of garbage. After completing wound care for Resident #34, LPN #3 gathered all remaining supplies, including package of gauzes, a medicine cup, one (1) 2 x 2 gauze, a bottle of normal saline, and a box of cloth tape and took all extra supplies out of room and went directly into Resident #1's room and placed the supplies on Resident #1's bedside table. The bedside table not cleaned prior to placing supplies nor was a barrier placed on the table. The scissors were not cleaned after being used for cutting tape for Resident #34's wound care and scissors were used to cut tape for Resident #1's wound care. LPN #3 again placed old wound dressing, soiled gauzes, and gloves in Resident #1's garbage can and did not remove after completing wound care. After completing wound care, LPN #3 removed supplies including gauzes, a bottle of normal saline, and the box of tape from Resident #1's room and took them to the medication cart. LPN #3 was observed cleaning scissors at the medication cart and allowed scissors to dry on a Kleenex before placing in medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 09:45 AM on 07/08/2021, during an interview with LPN #3, she explained she is not exactly sure when the last in-service was on wound care but does know she has been in-serviced. When asked why you would place supplies on a clean barrier in a resident's room, clean scissors after each use, and not take supplies from room to room, she explained to prevent spread of infections. She explained she did take all supplies from one resident ' s room to the other resident ' s room without cleaning the supplies. When ask to explain how she did wound care for each resident, she explained she gathered supplies, knocked on door and entered and provided privacy, and placed supplies on the bedside table. She explained she did not clean the bedside table for either resident before placing the supplies on the tables. When ask her what she did with the old dressings after completing wound care, she explained after removing the old dressing she placed the dressing and dirty gloves in the garbage can in residents' room by the door. LPN#3 was asked did you remove the dirty garbage from each room after completing wound care, she explained, no, I did not. She explained she did not even think about removing the garbage from the room, but the garbage should have been tied up and removed after completing the wound care to prevent the spread of infection. The SSA asked LPN#3 when she removed the supplies from the room, did she clean or disinfect any supplies before placing them back on top of the cart. She explained she only cleaned the scissors and did not wipe down the other supplies. She reported again that should be done to prevent infection. At 3:00 PM on 07/09/21 during an interview with the Interim Director of Nursing (IDON), she explained the medicine cart nurses do provide wound care when wound care nurse is off. She reported the wound care nurse can and does do Peg tube care sometimes when she works Monday through Friday. She explained she has educated all nurses while doing wound care to use a Ziplock bag and place all supplies in the bag and only take the bag in the room. She further reported the nurse should use the same bag for all dirty supplies and put the bag in the bag on the treatment cart. She explained she is not sure when last in-service was done but she has educated all nurses. When ask why should supplies not be taken from room to room and all supplies should be placed on a clean barrier in resident's room, she explained to prevent the spread of infection. Record review of sign in sheet for in-service for wound care dated 06/09/2021 revealed the in-service was conducted by RN #2 and LPN #3 attended the in-service. Resident #34 Record review of the Admission Record for Resident #34 revealed, the facility admitted Resident #34 on 10/18/2017 with the diagnoses of Type 2 Diabetes Mellitus with Hypoglycemia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting non-dominate side, Dysphagia, oropharyngeal phase, Dementia, and Dysphasia following other cerebrovascular disease. In record review of Resident #34's Order Summary Report revealed orders for cleanse Peg tube site with normal saline, pat dry with 4 x 4 gauze, and cover with split gauze one time a day. Record review of Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/12/2021 section C revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Admission Record revealed the facility admitted Resident #1 on 01/20/2021 with the diagnoses of Gastrostomy status, Dysphagia, Oropharyngeal phase, Cerebral Infarction, and Personal history of Transient Ischemic Attack. Record review Resident # 1's Order Summary Report revealed an order dated 6/18/21 for cleanse PEG site with normal saline, pat dry, and cover with split gauze one time a day. Record review of Entry Admission MDS with ARD of 05/11/2021, Section C revealed BIMS score of 06, indicating severe cognitive impairment.