STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255112	A. BUILDING _____ B. WING _____	03/05/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review facility policy review, the facility failed to ensure professional standards of practice were followed for [MEDICAL CONDITION] care per the care plan, for one (1) of four (4) bowel/bladder care observations, Resident #239. Findings include: A review of the facility's [MEDICAL CONDITION]/[MEDICAL CONDITION] Care policy, dated 08/24/2014, revealed, it is the responsibility of a licensed nurse to provide care for a [MEDICAL CONDITION]/[MEDICAL CONDITION], which includes removing the [MEDICAL CONDITION] bag and cleaning the skin. A review of Resident #239's care plan, revealed a focused problem related to alteration in gastro-intestinal status which indicated the use of a [MEDICAL CONDITION]. Interventions included to perform [MEDICAL CONDITION] care as ordered and as needed, and to be done by the Licensed Practical Nurse (LPN) or Registered Nurse (RN). . Review of the facility's Job Description for a Certified Nursing Assistant (CNA), dated 11/01/2017, revealed, the CNA provides direct non-professional resident care duties. Essential duties and responsibilities includes to notify the Charge Nurse and/or Registered Nurse (RN) Supervisor of any resident's change in condition. During an observation, of Resident #239's bath and incontinent care, on 03/02/2020 at 11:08 AM, revealed, the resident had a [MEDICAL CONDITION] bag, which was partially loose from skin. CNA #1 took the [MEDICAL CONDITION] bag off and began to clean the stoma, using personal cleaning cloth wipes containing Aloe. CNA #1 cleaned the stoma in a circular motion, three times using a new wipe each time. She then stated she was going to get the nurse to put another [MEDICAL CONDITION] bag on Resident #239. The stoma appeared pink in color. On 03/02/2020 at 11:30 AM, Licensed Practical Nurse (LPN) #2 entered Resident #239's room, washed hands, put on gloves, and explained to the resident that she was replacing his [MEDICAL CONDITION] bag. LPN #2 provided the care with no concerns noted. During an interview, on 03/04/2020 at 3:45 PM, LPN #2 revealed, CNA #1 should not have taken Resident #239's [MEDICAL CONDITION] bag off. LPN #2 stated the nurses are suppose to change the bag. LPN #2 revealed the resident could have been harmed and caused infection. LPN #2 stated CNA #1 was suppose to notify the nurse if a wound dressing was soiled. and a [MEDICAL CONDITION] bag needs changing. LPN #2 further stated the CNAs have been trained to go get nurse. LPN #2 stated CNA #1 told her the [MEDICAL CONDITION] bag was already off, and that she was trying to be helpful. On 03/04/2020 at 4:32 PM, during an interview, with the Director of Nursing (DON), she revealed CNA #1 was not [MEDICATION NAME] within her scope. The DON stated CNA #1 should have got a nurse and not removed the [MEDICAL CONDITION] bag. The DON further stated CNA #1's actions could have caused an infection control issue, by removing the [MEDICAL CONDITION] bag and cleaning the site. On 03/05/2020 at 2:37 PM, during an interview, CNA #1 revealed, she didn't know that CNAs could not take the [MEDICAL CONDITION] bag off. CNA #1 stated she touched Resident #239's stoma site to get feces off, so that it would not touch his bed. CNA #1 revealed she received an in-service today, and understands that what she had done could cause cross contamination, and the resident could get an infection.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to provide services and treatment for [REDACTED].#63. Findings include: Review of facility's Skin Care Process policy, dated 0[DATE]18, revealed: It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur. A review of Resident #63's Order Summary Report, as of 03/05/2020, revealed, an order, dated 12/19/2019, for treatment of [REDACTED]. On 03/04/2020 at 8:20 AM, Resident # 63 was observed sitting up in a Geri-chair at her bedside. On 03/04/2020 at 10:44 AM, during an observation of perineal care for Resident #63, Certified Nursing Assistant (CNA) #4 and CNA #5 turned Resident #63 on her left side, and it was noted that Resident #63's sacral pressure wound did not have a dressing to cover it. During an interview, on 03/04/2020 at 11:00 AM, with CNA #4 and CNA #5, they both stated the dressing was not on Resident #63's sacrum wound when they laid her down in the bed for the care. CNA #4 stated she laid Resident #63 down about 9:30 AM, and that Resident #63 was up in the Geri-chair when she came on to work at 7:00 AM. Both CNAs stated the policy was to notify the nurse when a wound dressing had come off, but they didn't tell the nurse, because they knew the wound care was going to be done that morning. An interview, on 03/05/2020 at 2:15 PM, with the Director of Nursing (DON), confirmed the policy was to notify the nurse immediately when the dressing was off any wounds. The DON stated there was a risk for infection, when the dressing was left off. Review of Resident #63's Admission Record, revealed, the resident was admitted by the facility on 07/06/2018, and had diagnoses, which included Pressure Ulcer of Unspecified Site, Unspecified Stage and Dementia.
F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and policy review, the facility failed to ensure [MEDICAL CONDITION] care was provided by a qualified person to prevent the possible spread of infection, for one (1) of four (4) incontinent care observations, Resident #239. Findings include: A review of the facility's [MEDICAL CONDITION]/[MEDICAL CONDITION] Care policy, dated 08/24/2014, revealed, it is the responsibility of a licensed nurse to provide care for a [MEDICAL CONDITION]/[MEDICAL CONDITION], which includes removing the [MEDICAL CONDITION] bag and cleaning the skin. A review of Resident #239's care plan, revealed a focused problem related to alteration in gastro-intestinal status which indicated the use of a [MEDICAL CONDITION]. Interventions included to perform [MEDICAL CONDITION] care as ordered and as needed, and to be done by the Licensed Practical Nurse (LPN) or Registered Nurse (RN) During an observation, of Resident #239's bath and incontinent care, on 03/02/2020 at 11:08 AM, revealed, the resident had a [MEDICAL CONDITION] bag, which was partially loose from skin. Certified Nursing Assistant (CNA) #1 took the [MEDICAL CONDITION] bag off and began to clean the stoma, using personal cleaning cloth wipes containing Aloe. CNA #1 cleaned the stoma in a circular motion, three times using a new wipe each time. She then stated she was going to get the nurse to put another [MEDICAL CONDITION] bag on Resident #239. The stoma appeared pink in color. Review of the facility's Job Description for a Certified Nursing Assistant, dated 11/01/2017, revealed, the CNA provides direct non-professional resident care duties. Essential duties and responsibilities includes to notify the Charge Nurse and/or Registered Nurse (RN) Supervisor of any resident's change in condition. On 03/02/2020 at 11:30 AM, Licensed Practical Nurse (LPN) #2 entered Resident #239's room, washed hands, put on gloves, explained to the resident that she was replacing his [MEDICAL CONDITION] bag, and proceeded to provide [MEDICAL CONDITION] care with no concerns noted. On 03/04/2020 at 3:45 PM, LPN #2 stated CNA #1 should not have taken Resident #239's [MEDICAL CONDITION] bag off. LPN #2 stated the nurses are suppose to change the bag. LPN #2 revealed the resident could have been harmed and caused infection. LPN #2 stated CNA #1 was suppose to notify the nurse if a wound dressing was soiled. and a [MEDICAL

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255112	A. BUILDING _____ B. WING _____	**03/05/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) CONDITION] bag needs changing. LPN #2 further stated the CNAs have been trained to go get nurse. LPN #2 stated CNA #1 told her the [MEDICAL CONDITION] bag was already off, and that she was trying to be helpful. During an interview, on 03/04/2020 at 4:32 PM, the Director of Nursing (DON) revealed, CNA #1 was not [MEDICATION NAME] within her scope. The DON stated CNA #1 should have asked to remove the [MEDICAL CONDITION] bag. The DON revealed, CNA #1's actions could have caused an infection control issue, by removing the [MEDICAL CONDITION] bag and cleaning the site. On 03/05/2020 at 2:37 PM, during an interview with CNA #1, she stated that she didn't know CNAs could not remove the [MEDICAL CONDITION] bag off of a resident. CNA #1 stated she touched Resident #239's stoma site to get feces off, so that it would not touch his bed. CNA #1 stated she received an in-service today, and understands that she could caused cross contamination by what she had done, and the resident could have gotten an infection.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to remove expired medication from the medication cart, for one (1) of four (4) medication carts observed. Findings include: A review of the facility's Storage of Medications policy, dated 09/05/2012, revealed, outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from stock, disposed of according to procedures for medication disposal. On [DATE]20 at 8:55 AM, during an observation of the South Hall medication cart, with Licensed Practical Nurse (LPN) #3, revealed an expired bottle of Magnesium [MEDICATION NAME] tablets - 100 count, with an expiration date of 11/2019. During an interview, on [DATE]20 at 9:10 AM, LPN #3 revealed the expired medications could cause harm to resident. LPN #3 stated the medication should have been pulled and discarded in November, and that it was the nurses' responsibility to check medication carts and pull expired medications. On [DATE]20 at 9:25 AM, during an interview with Registered Nurse (RN) #1, she revealed the medication should have been pulled, and should not have been in the cart. RN #1 stated expired medications could be less effective for the resident, and have the potential to cause harm. RN #1 stated all nurses are responsible for checking carts and removing expired medications.