Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Pleasant Hills Com LIV Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of ten (10) sampled residents, Resident #9. On 11/28/25, at approximately 10:40 AM a member of the facility staff observed Resident #9 with a Rollator exit the facility behind a visiting nurse. Resident # 9 was outside unsupervised for approximately 22 minutes. At 11:02 AM Resident # 9 was located 0.4 miles away from the facility down a busy four lane street in the parking lot of a local funeral home. The temperature at the time was 51 degrees; the resident was dressed in a sweatshirt and jeans.The facility's failure to provide adequate supervision to prevent the elopement of Resident #9 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/28/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of J. The SA notified the facility's Administrator of the IJ and SQC on 12/2/25, at 3:20 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 11/29/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 11/30/25, prior to the SA's first entrance on 12/1/25. Findings include:Record review of facility Elopement/Unsafe Wandering Plan dated 02/07/2012 revealed, Policy: It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life and safe environment procedures. Risk Evaluation: An evaluation of the resident's risk for unsafe wandering or elopement is to be conducted on admission, quarterly, after a significant change in condition, and after an incident of elopement. Identification: Residents at risk will have some type of identifier on their person. Plan of Care: If a resident is identified at risk for elopement or unsafe wandering, a preventative plan of care is to be implemented at the time the risk is identified. Unsafe wandering and/or elopement potential is to be entered into the ADL (activity of daily living) system and ADL plan of care. Supervision: Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary. Facility Systems: Systems such as alarms, Wanderguard systems and special locks/keypads as allowed by state and local authorities will be utilized to the extent possible.Record review of the admission Record for Resident #9 revealed the facility admitted the resident on 11/11/25 and the resident had diagnoses including Depression, Unspecified, Repeated Falls, and Chronic Atrial Fibrillation.Record review of the admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 11/18/25 for Resident #9 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors.Record review of the clinical note dated 11/26/2025 revealed the entry was labeled as New Recommendations and directed the reader to review the clinical notes for details. The note identified a new referral for psychiatric symptom management and a psychiatric medication review. The documented reason for referral was listed as new referral, psychiatric symptom management, and psychiatric medication review.During an interview on 12/03/24 at 11:30 AM Licensed Nursing Home Administrator (LNHA) described her understanding of the incident involving Resident 9. She stated she first became aware of the elopement when therapy staff sent a message reporting that the resident had been seen walking out of the facility. She said this occurred at 9:55 AM. She stated that staff should have verified the resident's location immediately and initiated the missing resident procedure without delay. She stated Registered Nurse (RN) # 1 last saw the resident at 10:37 AM, but staff did not maintain awareness of the resident's movement near the exit. She said the therapist observed the resident exiting behind a hospice Certified Nurse Aide who held the door open. She stated that this indicated a failure to follow the facility's Wandering and Missing Resident Procedures because staff did not block the exit or redirect the resident. She stated that between 10:37 AM and 10:40 AM no staff intervened to stop the resident, and no one initiated the Elopement and Wandering Prevention Plan as required. She said this allowed Resident #9 to leave the building unsupervised. The LNHA stated that Resident # 9 was found at 11:02 AM off the premises on a nearby street. She said the resident was near the roadway area and appeared anxious. She said the resident told staff that someone was trying to kill her. She confirmed that the resident was returned to the facility at 11:09 AM. During an interview 12/03/25 at 1:25 PM, Physical Therapist Assistant (PTA) # 1 revealed he returned to the building