STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255324	A. BUILDING _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUCE COMMUNITY LIVING CENTER	176 HIGHWAY 9 SOUTH BOX 1280 BRUCE, MS 38915

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 12/12/23 through 12/14/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F578 for Advance Directives and F641 for accuracy of assessments. The facility's census at the time of the survey was 31 with a bed capacity of 35 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		1/19/24

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

Electronically Signed | 12/29/2023

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.

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to have an informed consent for code status signed for two (2) of 16 sampled residents reviewed. Resident #3 and Resident #4 Findings include: Record review of facility policy titled, "Advance Directives", dated 11/22, revealed, "The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy." The policy also revealed, "Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident or legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used."	F 578	1. On 12/14/23 Social Service Director contacted resident #3 and Resident #4 Responsible Representative to complete updated facility advanced directives and code status forms to honor resident and representatives code status. On 12/14/23 Social Services Director was able to update code status forms according to the wishes of the Resident and Responsible Representative. 2. This alleged deficient practice has the potential to affect all residents. Social Service Director and Administrator performed an audit of all advanced Directive forms on 12/15/23. 3. On 12/14/23 Administrator in-serviced Social Service Director on policy for Advanced Directives, and Code Status during Admission Process. On 1/03/24	

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F 578	Continued From page 2 Resident #3 Record review of Resident #3's electronic Order Summary Report revealed an order dated 1/15/18 for "DNR". Record review of Resident #3's handwritten "Physician Orders" dated 6/8/23, revealed an order for "DNR". Record review of Resident #3's medical records revealed there was no signed consent by Resident #3 or Resident #3's Resident Representative that indicated the ordered DNR status was consented to. An interview with the Administrator on 12/13/23 at 8:15 AM, revealed the facility failed to have a signed code status or advance directive for Resident #3 to indicate the resident's or the resident representative's wishes for end-of-life care. She stated the facility had been in the process of developing a new form that would be consistent throughout the facility, but they realized several residents did not have a signed consent to indicate the resident's or the representative's wishes, only the electronic order and the signed physician order. She confirmed the residents' and the representatives' wishes needed to be honored and the code status needed to be discussed and verified by a signed consent to ensure proper care was given. An interview with the Social Services Coordinator on 12/13/23 at 3:05 PM, revealed she was responsible for having the advance directive and/or code status filled out on admission, as well as reviewing during each care plan meeting.	F 578	Administrator in-serviced Social Service Director on Resident Rights Policy and Procedure. On 12/15/23 Administrator and Social Service Director audited all current medical records to ensure correct code status was implemented by the facility, issues were corrected immediately. Starting 12/15/23 all current resident medical records were audited to ensure a copy of the Advanced Directives was placed on the medical record for all current residents, issues identified, and Responsible Representative and/or Power of Attorney were notified and requested to review and sign advanced directives with date certain by 01/18/2024. Medical Director was also made aware of all findings. 4. On 12/15/23 Administrator to review all new admission and change in status weekly x 4 weeks, bi-weekly x 2 weeks, monthly x 4 months to ensure the correct code status and advanced directive are accurately reflected in the resident chart and orders. Any issues will be immediately corrected. The administrator will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 6 months starting on 01/18/24. (January QAPI meeting date with MD).	

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F 578	Continued From page 3	F 578		

She confirmed that Resident #3's code status form "just slipped through the cracks", and therefore, it was not done. She confirmed the facility failed to have a consent signed to ensure the resident and family wishes were honored.

Record review of Resident #3's "Admission Record" revealed the resident was originally admitted to the facility on 3/7/17 and the most recent admission was 4/6/22. Resident #3's diagnoses included Chronic Obstructive Pulmonary Disease, Cognitive Communication Deficit, Hypertension, and Paroxysmal Atrial Fibrillation.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/14/23 indicated a Brief Interview for Mental Status (BIMS) of 0, which indicated the resident was severely cognitively impaired.

Resident #4

Record review of Physician Orders documented order for Resident #4 dated 09/25/23 for DNR and signed by physician.

Record review of Resident #4's Scanned Electronic Medical Records revealed that there was no signed consent for DNR (Do Not Resuscitate) status or Advanced Directive.

An interview with the Administrator on 12/13/23 at 8:18 AM, revealed the facility failed to have a signed code status or advance directive for Resident #4 to indicate the resident's or the

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F 578	Continued From page 4 resident representative's wishes for end of life care. She stated the facility had been in the process of developing a new form that would be consistent throughout the facility, but they realized several residents did not have a signed consent to indicate the resident's or the representative's wishes, only the electronic order and the signed physician order. She confirmed the residents' and the representatives' wishes needed to be honored and the code status needed to be discussed and verified by a signed consent to ensure proper care was given. Record review of Resident #4's Admission Record documented Admission Date of 09/28/2022 with the following diagnoses to include: Peripheral Vascular Disease, Cognitive Communication Deficit, Gout, Benign Neoplasm of Unspecified Adrenal Gland, and History of Falling. Record review of the MDS with an ARD of 11/03/23 revealed Resident #4 had a BIMS score of 03 indicating the resident was severely cognitively impaired.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and Resident Assessment Instrument (RAI) review, the facility failed to ensure that Minimum Data Set (MDS) was coded accurately for one (1) of 16 sampled residents. Resident #4.	F 641	1. On 12/13/23 Facility reviewed all falls with injury for the last 6 months for correct coding. Resident #4 was found with incorrect coding and a correction was submitted immediately. The correction	1/19/24

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F 641	Continued From page 5 Findings Include: Record review of typed statement on company letterhead documented: "The facility utilizes the MDS 3.0 Resident Assessment Instrument (RAI) Manual as the guide to complete the MDS." This document was signed by the Administrator but not dated. Record review of Resident Assessment Instrument (RAI) Version 3.0 Manual on page J-38 was documented under revealed, "Coding Instructions for J1900C, Major Injury Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment.....Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment...." Record review of Resident #4's MDS with Assessment Reference Date (ARD) of 11/03/2023 Section J1900 question relating to number of falls since admission entry was answered 1 under B. Injury (except major). Under C. Major Injury, which included bone fractures was answered 0 which indicated that resident had no fall with a major injury. On 12/13/23 at 9:54 AM, an interview with Registered Nurse (RN) #1, revealed that Resident #4 had a fall on 09/17/23 and was sent out to the Emergency Room (ER) with fractured ribs. On 12/13/23 at 9:40 AM, an interview with MDS Coordinator revealed that she was aware of Resident #4's fall in September, and she was	F 641	was accepted on 12/13/23 through the MDS submission portal with confirmation printed and filed. No other changes were needed. 12/15/23 Audit completed. 2.No other residents were affected but all residents with falls has the potential to be affected. 3. On 12/15/23 Administrator provided in-service to facility MDS Coordinator on Policy and Procedure of proper coding for falls through the MDS data bank using the RAI manuel help and instruction guide. Administrator and MDS Coordinator will perform weekly reviews of MDS submission for fall coding starting 12/29/23 weekly times 4 weeks, biweekly times 2 and monthly times 6. QAPI Committee Review times 4 weeks then monthly times 6 months. MDS Coordinator will print MDS submissions on all falls for review during our monthly QAPI meeting going forward. Starting 12/29/23 our DON will also review fall coding prior to MDS submission to ensure correct coding 4. Administrator will review MDS submission for falls weekly starting 12/29/23 times 4 weeks, biweekly times 2 and then monthly x 2 months. QAPI Committee will review times 4 weeks and then monthly x 6 months. All audits were completed on 12/15/23 for current residents by Administrator and MDS Coordinator. Monthly QAPI meeting with MD is scheudled 1/18/24.	

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F 641	Continued From page 6	F 641		

also aware the resident had a major injury from the fall. The MDS Coordinator revealed that she and the Administrator had discussed the fall with the injury. She revealed that when she did the MDS assessment in November, she mistakenly entered the fall as a fall with injury and not as a fall with a major injury. She stated that this was a mistake on her part when entering the information into the MDS system. She confirmed she would make a modification to ensure the entered information was accurate.

On 12/13/23 at 9:42 AM, an interview with the Administrator (ADM) revealed she was aware of the fall with a major injury, and this was discussed with the MDS coordinator as well during the stand-up morning meetings. ADM confirmed the facility failed to accurately enter the information into the system and the information entered should be accurate since it reflects the resident's condition.

Record review of Resident #4's "After Visit Summary" report from the hospital dated 09/18/2023 documented under "Narrative...Impression: ....Minimally displaced left posterior ninth and 10th rib fractures."

Record review of Resident #4's Admission Record documented admission date of 09/28/2022 with the following diagnoses to include: Peripheral Vascular Disease, Cognitive Communication Deficit, and History of Falling.