

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

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF BROOKHAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 519 BROOKMAN DRIVE BROOKHAVEN, MS 39601		
(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 two (2) Complaint Investigations (CI MS #28869 and CI MS #29097), at the facility from 6/02/25 through 6/04/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #28869 was investigated related to Accidents, Nursing Services, Neglect, Inappropriate Feeding Assistance and Quality of Care/Treatment regarding competent staffing and F656 and F880 were cited. CI MS #29097 was investigated regarding Resident Abuse, Resident Rights and Quality of Care/Treatment regarding resident safety and F550, F600, and F610 were cited.	F 000			
F 550 SS=E	The facility held a license for 58 beds, with a census of 53. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550			7/2/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/24/2025

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 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure care was provided in a manner that protected the dignity and privacy of residents for three (3) of four (4) sampled residents (Resident #1, Resident #2, and Resident #4). Specifically, the facility failed to maintain privacy during incontinence care for Resident #1 when staff provided care with the window curtain open, exposing the resident's perineal area; failed to provide a catheter bag cover for Resident #2 to maintain dignity; and failed to assist Resident #4 with meals in a respectful manner by standing over the resident while providing feeding	F 550			

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F 550	Continued From page 2 assistance, rather than sitting at the resident's side. Findings Include: A review of the facility's policy, "Resident Rights and Quality of Life", dated 3/13/20 revealed, "...It is the policy of ...that all residents and patients have the right to a dignified existence ..." A record review of the facility's "Peri (Perineal) Care Audit Tool, undated, revealed "Action" including "Staff must ...provide privacy (door, window, room divider curtain ..." Resident #1 Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/05/24 and she had current diagnoses including Alzheimer's Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/25 revealed for Resident #1's Cognitive Skills for Daily Decision Making was Severely Impaired. On 6/03/25 at 10:45 AM observation revealed Certified Nursing Assistant (CNA) #3 and CNA #5 provided incontinent care for Resident #1 in her bed in her room next to the bed with the bed elevated and the double window curtain open; the window on the right was open approximately two (2) inches. The view from the window was the facility front yard and front porch and portico and the front parking lot and sidewalk. After positioning the resident and her clothing, CNA #5 exposed Resident #2's perineal area and after	F 550			

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F 550	Continued From page 3 cleaning the front of the resident's perineal area turned the resident toward the window and cleaned the resident's back perineal area. Resident #2 Record review of the "Admission Record" revealed the facility admitted Resident #2 on 5/09/25 with current diagnoses including Urinary Tract Infection. Record review of the Admission MDS with an ARD of 5/16/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. On 6/02/25 at 3:44 PM, an observation revealed Resident #2's catheter drainage system collection bag was uncovered, containing clear yellow fluid. Resident #4 On 6/03/25 at 11:10 AM observation revealed CNA #5 standing at the bedside of Resident #4 assisting the resident to eat a midday meal (lunch). Record review of the "Admission Record" revealed the facility admitted Resident #4 on 6/02/25 with current diagnoses including Senile Degeneration of Brain. Record review of the medical record for Resident #4 revealed the baseline care plan and MDS had not been completed for the resident at the time of survey. On 6/03/25 at 1:34 PM, an interview with CNA #5 revealed she was assigned to the care of	F 550			

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F 550	Continued From page 4 Resident #1 and Resident #2 on 6/02/25 and 6/03/25. She said she was aware that Resident #2 did not have a catheter bag cover in place and that it was supposed to be covered but said she was not aware why. She stated that she stood to assist Resident #4 to eat lunch because there was no chair in the room and that she was not aware that she was supposed to be seated at the residents' side to assist with eating meals. She stated that she had not noticed that Resident #1's window curtain was open when she exposed the resident and provided incontinence care at 10:45 AM. On 6/04/25 at 11:11 AM an interview with the Director of Nursing Services (DNS) revealed that catheter bags should be covered to ensure the dignity of residents with catheter drainage systems. She stated that during incontinence care staff should provide privacy by closing the room door, privacy curtain and window curtains to maintain the dignity of the resident. She stated that when feeding a resident that required assistance with eating staff should be seated at the side of the resident with the purpose of maintaining the dignity of the resident.	F 550			
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		7/2/25	

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F 600	Continued From page 5 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to protect residents right to be free from verbal, mental, and physical abuse for two (2) of four (4) sampled residents (Resident #2 and Resident #3). Specifically, Certified Nurse Aide (CNA) #1 verbally and physically abused Resident #2 during incontinence care on 5/21/25 by striking the resident's legs, scolding him, and failing to provide care in a safe, supportive, and respectful manner, resulting in the resident experiencing fear, shame, emotional distress, and feelings of helplessness. Additionally, CNA #1 verbally and mentally abused Resident #3 on 5/21/25 by scolding and berating the resident for incontinence, causing the resident to feel humiliated, ashamed, and fearful that the behavior would recur. Findings Included: Record review of the facility's "Abuse, Neglect, Misappropriation, Exploitation Policy", dated January 2019, revealed, " ...Purpose: To prohibit and prevent abuse, neglect ...Definitions: Abuse: The willful infliction of ...intimidation ...with resulting physical harm, pain or mental anguish. A record review of the "Investigation Template", dated 5/21/25, revealed the facility described the allegation that Resident #2 reported that a CNA	F 600			

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F 600	Continued From page 6 had hit him on the leg with both hands because he was wearing a condom catheter. The "Investigation Summary" indicated that Interviews with all residents with BIMS (Brief Interview for Mental Status) greater than eleven." A review of the "Summary of Interview" revealed Resident #2 stated he was hit last night on his legs. Another "Summary of Interview" revealed Resident #3 indicated "The CNA ...that was assigned to him on 11pm-7pm was pissed off with him because he had urinated in the bed and she had to change him." Resident #2 Record review of the "Admission Record" revealed the facility admitted Resident #2 on 5/09/25 with current diagnoses including Urinary Tract Infection. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Further review revealed Resident #2 had no behavioral issues, was always incontinent of bowel and bladder, and was dependent for toileting hygiene and required substantial/maximal assistance to roll left and right on bed. Record review of the Social Services Progress Note for Resident #2, dated 5/21/25 at 14:49 (2:49 PM) revealed the Social Services and Admissions Liaison (SSD) documented that she visited the resident "to ask about the incident that happen over night with the CNA. I let him know that we would handle the situation asap (as soon	F 600			

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F 600	Continued From page 7 as possible). That we would make sure nothing like this ever happened again to him or anyone else". On 6/02/25 at 11:45 AM, an interview with Resident #2 with the assistance of his communication device revealed the resident stated that during the early hours of 5/21/25 Certified Nurses' Aide (CNA) #1 entered his room and discovered that his condom catheter had come off and his incontinence brief was wet, and he thought she acted like she got mad. He reported that when she started to turn him during incontinence care he had muscle spasms in his legs and the CNA struck him twice on his legs and told him to stop tensing up. He said he had involuntary muscle spasms and took medication for them. He said that he had not tried to communicate with the CNA after she struck him because he was scared. He said this incident upset him because he was dependent and could not defend himself. He said he immediately wanted to go home because nobody treated him like that at home, and he was afraid because the incident could occur again. He said that he was unable to go back to sleep and cried due to feeling afraid and humiliated. He confirmed the incident caused him to feel shame, fear and demeaned. He said he only agreed to remain at the facility after being assured that CNA would not be allowed back into his room and confirming that his wife could stay with him at night until he could complete his therapy and return home as scheduled. On 6/02/25 at 12:10 PM, an interview with the Resident Representative (RR) for Resident #2 revealed she had been notified of the resident's allegation of abuse on 5/21/25. She stated that	F 600			

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F 600	Continued From page 8 when she arrived, he was very upset and demanded to go home immediately. She stated that her immediate reaction was to take him home, but that he was doing very well with his therapy and the two of them agreed for him to stay with her spending nights in his room with him. On 6/02/25 at 2:25 PM an interview with CNA #2 revealed she reported she had worked 7-3 shift on 5/21/25 and at approximately 7:30 PM she entered the room of Resident #2, and he was resting in bed with tears on his face and crying. She said she asked him what was wrong, and he used his communication device to tell her that he had been hit. She said she asked him who hit him, and he typed in the name of CNA #1. She stated that the resident told her he had been scared and crying and wanted to go home because no one hit him at home. She said she had immediately reported the allegation of abuse to the former Assistant Director of Nursing Services (ADNS). Resident #3 Record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/27/25 with current diagnoses including Benign Neoplasm of Cerebral Meninges. Record review of the Admission MDS with an ARD of 4/03/25 revealed Resident #3 had a BIMS score of 8, which indicated his cognition was moderately impaired. Further review revealed he had no behaviors, was always incontinent of bowel and bladder, and required substantial/maximal assistance for toileting hygiene and moderate assistance to roll left and	F 600			

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F 600	Continued From page 9 right on bed. On 6/02/25 at 3:50 PM during interview with Resident #3 in his room, he revealed that during the early morning hours of 5/21/25, CNA #1 had entered his room and scolded him for wetting his bed. He said that made him feel ashamed and said, "I can't help wetting the bed; if I could, I wouldn't do it. It made me feel like getting up and getting out of here and I would have if I could." The resident said the incident made him feel shame and humiliated for wetting the bed and he was afraid because CNA #1 intimidated him while scolding him and that he was afraid the incident may recur. On 6/03/25 at 2:54 PM, during a telephone interview the former ADNS, she stated that she was the nurse assigned to the care of Resident #1 on 5/21/25 and was made aware of an allegation of abuse by Resident #2 around 7:30 AM by CNA #2. She said she immediately assessed and interviewed Resident #2 who was actively crying and told her that CNA #1 had hit his legs during the earlier hours of 5/21/25 when he wet his brief and then had muscle spasms in his legs during incontinence care and berated him to stop tensing up. She reported she had also assessed the resident, and his condom catheter was off, but in his brief. She said she had spoken with CNA #1 at approximately 6:45 AM on 5/21/25 and the CNA had asked her if the resident had any more condom catheters. She stated that the resident was traumatized and that on 5/21/25 the resident's wife had started spending the night with the resident in his room. She said that she was unaware of any other complaint ever made by Resident #2. She stated that as part of the investigation into Resident #2's allegation, she	F 600			

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F 600	Continued From page 10 interviewed and assessed Resident #3 who reported that CNA #1 had "scolded" him because he had wet his bed. On 6/04/25 at 9:30 AM, during a telephone interview the District Ombudsman revealed she had received a report from the RR for Resident #2 that the resident had been struck by CNA #1 who spoke to him in a demeaning manner that made him feel degraded. She said the facility staff reported that CNA #1 had confirmed "tapping" the resident's leg. The Ombudsman said that there was no report given to her that Resident #3 had also reported verbal or mental abuse by CNA #1 during the same shift. On 6/04/25 at 10:35 AM, an interview with the Social Services and Admissions Liaison (SSD) revealed she was made aware of the allegation of abuse by Resident #2 on the morning of 5/21/25, a little after 8:00 AM and visited him on 5/21/25 "to make sure he wasn't too upset and see if I needed to try to make him feel better and reiterate to him that the incident wouldn't happen again." She stated that she recalled "somebody said something about Resident #3 saying CNA #1 got upset with him because he wet his bed" but she did not visit the resident. On 6/04/25 at 11:11 AM, an interview with the Director of Nursing Services (DNS) revealed she was made aware of the allegation of abuse reported by Resident #2 by the Administrator at home on the morning of 5/21/25 via telephone call. She stated that she called CNA #1 and notified her that she was suspended pending investigation. She stated she had completed a couple of coaching sessions with CNA #1 in November 2024 related to resident care and	F 600			

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F 600	Continued From page 11 Resident Rights and the CNA's assignment was changed to another group "for the resident's comfort". She stated she became aware of the allegation of abuse by Resident #3 when she read the final draft of the investigation prior to sending it to the State Agency (SA) on 5/24/25. She stated that she was not aware of any follow-up investigation, interventions, or counseling provided as a result of the allegation by Resident #3. She said she felt CNA #1 had adequate information and training to provide appropriate care for Resident #2 and Resident #3. On 6/04/25 at 11:25 AM, during a telephone interview with CNA #1, she said she had 'patted' Resident #2 on his leg to get him to relax during incontinence care on the morning of 5/21/25. She stated it was possible she was frustrated. She said Resident #2 "had never acted like that before, never tensed up before. It's harder on me.". She explained that she had entered the room to empty the resident's catheter drainage bag, but it was empty, and she checked his brief, and it was wet. She noted his condom catheter had come off and she had to provide incontinent care and change his brief. She said she had told him that she was going to have to change his brief and when she started to turn him, his legs were tensed up and she was unable to turn him. She said she patted his leg and told him to relax and was then able to turn him onto his side and completed incontinence care. She said nobody ever told her that Resident #2 had muscle spasms. She said that Resident #2 used a communication device that was always on his over the bed table but that the device was not in his reach and he did not have it, and she did not give it to him. She said, "When I talk to him, I try	F 600			

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F 600	Continued From page 12 to understand him without using the tablet. I didn't use or give him the tablet". She said the resident didn't say anything to her. She reported that when she made final rounds, she entered Resident #3's room and was frustrated with him because "he had peed out the bed. I think it was intentional." CNA #1 said she had fussed at Resident #3 and said, "I shouldn't have, but I did. I told him he needed to stop urinating in bed. I had to change the bed and his clothes and give him a bed bath three (3) times during the shift". She said Resident #3 didn't respond. She said the DNS had called her at home and she had to meet with the DNS and the Administrator and was written up regarding the allegation by Resident #2 but was not asked any questions regarding Resident #3. She confirmed that she had complaints made against her and received coaching from the DNS in November 2024 and said, "Usually I get changed to another hall". On 6/04/25 at 1:50 PM an interview with the Administrator revealed she was made aware of the allegation of abuse by Resident #2 on the morning of 5/21/25 by the ADNS. She said actions taken to protect the residents during the investigation included placing CNA #1 on suspension. She confirmed that the facility investigation determined the allegation of abuse was unfounded because there were no witnesses and no apparent injury such as bruise or abrasion. She acknowledged that Resident #2 had new behaviors of crying and had not made any allegations before or since the allegation of abuse voiced on 5/22/25 and she was aware that Resident #2's wife began to stay with him overnight in his room. She stated CNA #1 was brought back with training to educate regarding abuse and neglect prevention and resident rights	F 600			

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F 600	Continued From page 13	F 600			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, record review and interviews the facility failed to conduct a thorough investigation of an allegation of verbal and mental abuse for one (1) of two (2) sampled residents that reported an allegation of abuse, Resident #3. Findings included: Policy review of the facility titled "Abuse, Neglect, Misappropriation, Exploitation Policy with Effective Date January 2019 revealed " ...Investigation If actual violation or alleged violation occurs the resident will immediately be	F 610		7/2/25	

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F 610	Continued From page 14 assessed and removed from any potential harm (as applicable). The Administrator, or designee will oversee the center in conducting an internal investigation against any violation/alleged violation of abuse ...Investigations will be prompt, comprehensive and responsive to the situation ...The investigation will include ...Notification of the physician and resident or resident representative ...Interviews of all involved persons ...Follow-up resolution ...All material and documentation of the pertinent data to the investigation is collected, maintained and safeguarded by the center ..." A record review of the "Investigation Template", dated 5/21/25, revealed the facility described the allegation that Resident #2 reported that a CNA had hit him on the leg with both hands because he was wearing a condom catheter. The "Investigation Summary" indicated that interviews were conducted with all residents with BIMS (Brief Interview for Mental Status) greater than eleven." A review of the "Summary of Interview" revealed Resident #2 stated he was hit last night on his legs. Another "Summary of Interview" revealed Resident #3 indicated "The CNA ...that was assigned to him on 11pm-7pm was pissed off with him because he had urinated in the bed and she had to change him." During an interview on 6/02/25 at 3:50 PM, Resident #3 revealed that during the early morning hours of 5/21/25, CNA #1 had entered his room and scolded him for wetting his bed. He said that made him feel ashamed and said, "I can't help wetting the bed; if I could, I wouldn't do it. It made me feel like getting up and getting out of here and I would have if I could.". The resident said the incident made him feel shame and he	F 610			

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F 610	Continued From page 15 was afraid because the CNA #1 scolded him and that he was afraid the incident may recur. He confirmed he had reported the incident to the Assistant Director of Nursing Services (ADNS) on 5/21/25 and did not remember anybody else coming to ask him about it. During a telephone interview on 6/03/25 at 2:54 PM, the former ADNS stated that she was involved in an investigation into an allegation of abuse for a different resident on 5/21/25 and interviewed and assessed Resident #3. She stated that during the interview Resident #3 reported verbal and mental abuse by CNA #1 on the morning of 5/21/25. She said that Resident #3 reported that CNA #1 had scolded him for wetting his bed. She said she reported the allegation to the Administrator on 5/21/25. During an interview on 6/04/25 at 10:35 AM, the Social Services and Admissions Liaison (SSD) said regarding the allegation of verbal and mental abuse by Resident #3 she recalled "somebody said something about Resident #3 saying the CNA got upset because he wet his bed" but she was not requested or instructed to visit the resident and had not visited, interviewed or assessed Resident #3 following the allegation. During an interview on 6/04/25 at 11:11 AM, the Director of Nursing Services (DNS) revealed that she became aware of the allegation of abuse by Resident #3 when she read the final draft of the investigation prior to sending to SA on 5/24/25. She stated that she was not aware of any follow-up with Resident #3's allegation or any investigation into the allegation. During a telephone interview on 6/04/25 at 11:25	F 610			

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F 610	Continued From page 16 AM, CNA #1 said that when she made final rounds on the morning of 5/21/25 she entered the room of Resident #3 and "was frustrated with him because he had peed out the bed. I think it was intentional.". She said she had fussed at Resident #3 and said, "I shouldn't have but I did. I told him he needed to stop urinating in the bed. I had to change the bed and his clothes and give him a bed bath three (3) times during the shift". She said the DNS called her and she had been suspended pending an investigation into a separate allegation and had to meet with the DNS and the Administrator and was written up regarding the allegation by a different resident but was not asked any questions regarding Resident #3. During an interview on 6/04/25 at 1:50 PM, the Administrator revealed that she was notified of the allegation by Resident #3 on 5/21/25 by the ADNS (former) and stated "He told (ADNS) that the CNA was pissed off at him because he wet the bed"; she confirmed that Resident #3 was incontinent of bowel and bladder and required incontinence care by staff. She stated that the allegation was not investigated, and no psychosocial assessment, treatment or counseling were offered to or provided for Resident #3. The Administrator said she did not know why the resident reported that the CNA was "pissed off" or how he got that impression. She said she was unaware of how the interaction between CNA #1 and Resident #3 made him feel. She stated she had not asked CNA #1 about the allegation reported by Resident #3 during the investigation into the allegation of abuse reported by Resident #2. Record review of the "Admission Record"	F 610			

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F 610	Continued From page 17 revealed the facility admitted Resident #3 on 3/27/25 with current diagnoses including Benign Neoplasm of Cerebral Meninges. Record review of the Admission MDS with an ARD of 4/03/25 revealed Resident #3 had a BIMS score of 8, which indicated his cognition was moderately impaired. Further review revealed he had no behaviors, was always incontinent of bowel and bladder, and required substantial/maximal assistance for toileting hygiene and moderate assistance to roll left and right on bed.	F 610			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/2/25	

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F 656	Continued From page 18 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions for one (1) of four (4) sampled residents reviewed for care plan implementation, Resident #1. Findings included: A review of the facility's policy titled "Care Plans", 09/2020, revealed, " ...Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines ..." A record review of the "Care Plan Report"	F 656			

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F 656	Continued From page 19 revealed Resident #1 had a "Focus" of "At risk for falls ..." with "Interventions" including "Resident to be taken to the dining room for meals," initiated on 4/28/25. On 6/2/25 at 12:00 PM, during an observation, Resident #1 was observed seated in her wheelchair in the hallway next to the door of her room, across from the nurses station, assisted by staff while eating lunch. On 6/3/25 at 12:00 PM, during an observation, Resident #1 was observed seated in her wheelchair in the hallway next to the door of her room, across from the nurses station, assisted by Certified Nurse Aide (CNA) #3 while eating lunch. On 6/3/25 at 2:05 PM, during an interview with CNA #7, she stated that she observed Resident #1 eating all meals either in her room or in the hallway outside her room. She stated that was where the resident usually ate all her meals. She confirmed she was unaware of the care plan intervention for Resident #1 to eat meals in the dining room. She stated that evening meals (suppers) were served in the dining room with staff present to assist residents as needed. On 6/4/25 at 11:11 AM, during an interview with the Director of Nursing Services (DNS), she stated that care plan development and implementation were very important to ensure proper and appropriate care for each resident. She stated she expected staff to follow through with interventions listed in each resident's care plan. She confirmed that the care plan intervention for Resident #1 to eat in the dining room was developed as a fall prevention measure.	F 656			

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F 656	Continued From page 20 On 6/4/25 at 1:50 PM, during an interview with the Administrator, she stated that care plan development and implementation were very important to ensure residents receive proper care. She stated she expected staff to follow through with care plan interventions. She further stated that failure to develop or implement care plans could result in residents not receiving needed care, leading to potential negative outcomes. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/05/24 and she had current diagnoses including Alzheimer's Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/25 revealed for Resident #1's Cognitive Skills for Daily Decision Making was Severely Impaired.	F 656			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/2/25	

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F 880	Continued From page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	Continued From page 22 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow hand hygiene practices consistent with accepted standards of practice during incontinence care for one (1) of four (4) sampled residents reviewed for incontinence care, Resident #1. Findings included: A review of the facility's "Peri (Perineal) Care Audit Tool," undated, revealed "Action" including, " ...7. STOP! Removes gloves, washes/sanitizes hands and re-gloves. 8. Applies clean brief, dresses resident..." On 6/4/25 at 10:45 AM, during an observation, Certified Nurse Aide (CNA) #3 and CNA #5 provided incontinence care for Resident #1. After completing the care, the CNAs did not perform hand hygiene or change gloves before applying a clean brief and adjusting the resident's clothing. On 6/4/25 at 11:11 AM, during an interview with the Director of Nursing Services (DNS), she	F 880			

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF BROOKHAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 519 BROOKMAN DRIVE BROOKHAVEN, MS 39601		
(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 880	Continued From page 23 stated that during incontinence care, staff were supposed to stop after cleaning a resident with a wet and/or soiled brief, change gloves, and perform hand hygiene by washing hands or using hand sanitizer prior to donning clean gloves. She stated gloves should be changed as often as necessary but at least one time between handling wet/soiled briefs and applying clean briefs and adjusting the resident's clothing. On 6/4/25 at 1:34 PM, during an interview with CNA #5, she confirmed that at 10:45 AM, when she provided care for Resident #1, she did not change her gloves or perform hand hygiene. She stated she understood that improper incontinence care could contribute to the development of urinary tract infections (UTIs). On 6/4/25 at 1:50 PM, during an interview with the Administrator, she confirmed that she expected staff to provide care in accordance with current infection control standards as outlined in the facility's policies and procedures and as instructed during in-service and training. A record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 4/5/24 with current diagnoses including Alzheimer's Disease. A record review of Resident #1's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 5/20/25 revealed the resident's Cognitive Skills for Daily Decision Making were severely impaired.	F 880			