

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255324		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2025	
NAME OF PROVIDER OR SUPPLIER BRUCE COMMUNITY LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 176 HIGHWAY 9 SOUTH BOX 1280 , BRUCE, Mississippi, 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	
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS # 2561208) at the facility on 8/19/25. During the survey the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F 550, F558, and F609. The SA investigated Abuse/ Neglect and Resident Rights. The facility held a license for 35 beds, with a census of 31.		F0000				
F0550 SS = D	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 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.		F0550				

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 reverse for further 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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F0550 SS = D	Continued from page 1 §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 resident and staff interviews, record review, and facility policy review, the facility failed to honor a resident's expressed preference for care and provide services in a manner that maintained and promoted dignity. This failure resulted in Resident #1 not receiving care as requested, leaving her wet and uncomfortable, for one (1) of four (4) residents reviewed for dignity concerns (Resident #1). Findings include: Review of the facility policy titled, "Resident Rights," last revised November 28, 2016, revealed: "(a) 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. ... (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 residents..." An interview with Resident #1 on 8/19/25 at 3:35 PM revealed that on the night of 6/23/25, she requested that Certified Nurse Assistant (CNA) #1 clean her back with a washcloth. She stated CNA #1 refused and attempted to use cleansing wipes instead. Resident #1 stated she told CNA #1 to leave if she would not do it the way she asked. She further stated that Licensed Practical Nurse (LPN) #1 came into her room and told her that if she did not allow CNA #1 to change her, she would have to wait until staff were finished with other residents. An interview with CNA #1 on 8/19/25 at 5:23 PM she stated that the night of 6/23/25 Resident #1 asked her	F0550					

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F0550 SS = D	Continued from page 2 to clean her back with a warm wet washcloth, but what she had on hand was wet wipes. CNA #1 stated she did not think at the time of just going get a washcloth as the resident asked and confirmed there were washcloths on the linen cart. Review of a Resident Investigation Report Form related to Resident #1 revealed an Interview Summary dated 6/24/25 conducted by the Administrator. CNA #1 stated: "I went in to dry her, and while I had the resident turned over on her side, she asked me to rinse her back off with a washcloth because they had left soap on her during her bath that day. I explained to Resident #1 I had wipes with me, so I wiped her back with a wipe and then started to change her. Resident #1 stated, 'Well, they did not get all the soap off of me.' I told her again that I had cleansing wipes with me but did not have a washcloth at the time." Further review of the same Resident Investigation Report Form revealed an Interview Summary dated 6/26/25 conducted by the Director of Nursing. LPN #1 stated CNA #1 reported Resident #1 was refusing care because she had been cleaned with wipes instead of a washcloth. LPN #1 stated she told the resident it was her right to refuse, but if she did not allow staff to finish, "she would have to lay there wet until the staff finished with the other residents, and that could be a while." In an interview with the Administrator on 8/19/25 at 6:34 PM, she confirmed the incident was a dignity concern. She stated CNA #1 should have provided care using a washcloth as the resident requested. She acknowledged that failing to do so could have made the resident feel her voice was not heard. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 4/05/24 with a diagnosis of chronic obstructive pulmonary disease. Record review of the Quarterly Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 6/26/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired.		F0550				
F0558 SS = E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so		F0558				

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F0558 SS = E	Continued from page 3 would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure call lights and frequently used items were maintained within residents' reach for three (3) of four (4) residents observed (Residents #1, #2, and #3). Findings include: Review of the facility policy titled, "Call Light, Use Of," last revised August 2014, revealed: "...Procedure: When providing care to residents be sure to position the call light conveniently for the resident to use..." Resident #1 During an observation and interview with Resident #1 on 8/19/25 at 3:35 PM, she stated that on the evening of 6/23/25 her call light and phone were not within her reach. She explained that her call light was often on the floor and her phone was also on the floor, leaving her unable to call for assistance when she needed help. An observation revealed Resident #1's call light lying on the floor under the bed, with no clip observed on the cord to keep it accessible. An observation of Resident #1's room on 8/19/25 at 5:30 PM with Certified Nurse Assistant (CNA) #1 confirmed the call light was not in reach and was located on the floor under the bed. Review of the "Admission Record" revealed Resident #1 was admitted on 4/05/24 with a diagnosis of chronic obstructive pulmonary disease. Review of the Quarterly Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 6/26/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired. Resident #2 An observation of Resident #2 on 8/19/25 at 3:32 PM revealed she needed to be changed. When asked if she called for someone to help her, she stated she could not reach her call light. She was observed attempting to reach the call light, which was attached to the top		F0558				

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F0558 SS = E	Continued from page 4 of the upper side rail, and not accessible. An observation of Resident #2 on 8/19/25 at 4:34 PM with CNA #2 confirmed the resident's call light was not in reach. CNA #2 stated that concerns with call lights being out of reach include residents missing needed care. Review of the "Admission Record" revealed Resident #2 was admitted on 4/14/25 with a diagnosis of bilateral primary osteoarthritis of first carpometacarpal joints. Review of the Quarterly MDS for Resident #2 dated 7/17/25, Section C, revealed a BIMS score of 12, indicating the resident was moderately cognitively impaired. Resident #3 An observation of Resident #3 on 8/19/25 at 3:48 PM revealed the resident's call light lying on his nightstand across the room. During an interview, he stated he could not reach his call light. He explained that if he needed it, he would either climb across the bed or get in his wheelchair and roll out to the hallway for help but stated "that was hard to do." An observation of Resident #3 on 8/19/25 at 5:36 PM with CNA #1 confirmed the call light was across the room and out of the resident's reach. She stated concerns included the resident being unable to call for help, attempting to get the call light and risking a fall, or having unmet needs. Review of the "Admission Record" revealed Resident #3 was admitted on 6/02/22 with a diagnosis of cerebral infarction. Review of the Quarterly MDS for Resident #3 dated 6/24/25, Section C, revealed a BIMS score of 15, indicating the resident was cognitively intact. An interview with Licensed Practical Nurse (LPN) #2 on 8/19/25 at 5:37 PM revealed if a resident's call light was not in reach and the resident experienced a medical emergency, they would not be able to call for help. An interview with the Administrator on 8/19/25 at 6:34 PM confirmed that frequently used items such as call lights and phones should always be within residents' reach. She stated concerns with items being out of reach, included residents being unable to call staff if needed, potentially delaying care.	F0558					
F0609	Reporting of Alleged Violations	F0609					

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F0609 SS = D	Continued from page 5 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 staff interview, record review, and facility policy review, the facility failed to ensure allegations of abuse/neglect were reported to the State Agency within the required timeframe for one (1) of three (3) residents reviewed for reporting. (Resident #1) Findings include: Review of the facility policy titled, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Policy," dated January 2019, revealed: "...7. Reporting/Response: ...Immediately reporting all alleged violations to the ...state agency, adult protective services and to all other required agencies within specified timeframes..." A phone interview with the Ombudsman on 8/19/25 at 10:00 AM revealed that she was at the facility on			F0609			

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F0609 SS = D	Continued from page 6 6/24/25 when Resident #1 made allegations of verbal abuse and neglect involving a Certified Nurse Assistant (CNA) #1 and Licensed Practical Nurse (LPN) #1. The Ombudsman stated she immediately reported the allegations to the Administrator. She further stated that when she followed up with the Administrator on 7/8/25, she discovered the allegation had not been reported to the State Agency and subsequently reported it herself. During an interview with the Administrator on 8/19/25 at 4:39 PM, she confirmed the Ombudsman informed her on 6/24/25 of Resident #1's allegations of verbal abuse and neglect. She acknowledged she did not notify the State Agency within the required timeframe and confirmed she should have. She stated the importance of reporting is that it is part of the investigation process and serves to keep residents safe. Review of the Investigation Report for Resident #1 revealed: "Date of Incident: 6/23/25. Date Incident Reported: 6/24/25 Ombudsman asked facility to investigate." ... Results reported to State Licensing Agency: 7/8/25. Review of the "Admission Record" revealed Resident #1 was admitted to the facility on 4/05/24 with a diagnosis of chronic obstructive pulmonary disease.	F0609					