| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIVERSICARE OF BROOKHAVEN | 519 BROOKMAN DRIVE , BROOKHAVEN, Mississippi, 39601 |

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| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a Complaint Investigation (CI) at the facility on 10/20/25 through 10/21/25 for CI MS#2633663 for Physical Environment related to inadequate supply of incontinence supplies, Quality of Care related to failure to provide or postponement of activities of daily living, and Dietary Services. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and there were four (4) deficiencies cited: F558, F690, F880, and F921.<br><br>The facility held a license for 58 beds, with a census of 56. | F0000 | | |
| F0558<br>SS = D | Reasonable Accommodations Needs/Preferences<br><br>CFR(s): 483.10(e)(3)<br><br>§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 would endanger the health or safety of the resident or other residents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, policy review, and interviews the facility failed to ensure the right of the residents to reside and receive services in the facility with reasonable accommodation of resident needs to achieve independent functioning, dignity and well-being that reflect the resident's needs, specifically to call system within reach for two (2) of six (6) sampled residents, Resident #1 and Resident #4.<br><br>Findings included:<br><br>Policy review of the facility policy titled, "Nurse Call System" Effective Date 9/01/14, revealed the policy revealed, "2. Each cord needs to be visible and reachable by the resident to which it operates for..."<br><br>Resident #1 | F0558 | | |

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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| F0558 SS = D | Continued from page 1<br>On 10/20/25 at 1:25 PM during observation and interview with Resident #1 in his room revealed the call light for Resident #1 was attached to the transfer bar on the right side of the resident's bed by a clamp and not within the reach of the resident seated in his wheelchair on the left side of the bed. Resident #1 stated that he was not able to reach the call light.<br><br>Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/25 revealed a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact.<br><br>Resident #4<br><br>On 10/21/25 at 12:25 PM observation and interview with Resident #4 revealed the resident was resting in his bed, which was against the wall facing the door with head of bed elevated and his call light was coiled and lying on the floor behind the head of the resident's bed. Resident #4 confirmed that he was not able to reach his call light.<br><br>Record review of Resident #1's MDS with an ARD of 9/19/25 revealed a BIMS score of 6, indicating severely impaired cognition.<br><br>On 10/21/25 at 12:40 PM observation and interview with the Administrator in the rooms of Resident #1 and Resident #4 revealed that she confirmed that Resident #1's call light was not within his reach as he was seated in his wheelchair on the left side of the bed and the call light was attached to his bed's right transfer bar. The Administrator confirmed that Resident #4 could not reach his call light coiled and lying on the floor behind the head of his bed.<br><br>On 10/21/25 at 1:03 PM during an interview, Certified Nursing Assistant (CNA) #5 stated that she was assigned to the care of Resident #1 and Resident #4. She stated that she had not touched the call light of Resident #1 all day and confirmed that the call light was not in reach of the resident as he was seated in his wheelchair on the left side of the bed and the call light was attached to his bed's right transfer bar. She confirmed that making sure each resident's call light was within their reach was important to ensure the residents could call for assistance as needed. She said that Resident #4 could not reach his call light coiled up and lying on the floor behind the head of his bed. She said she had not noticed that the resident's call light had been out of their reach.<br><br>On 10/21/25 at 1:30 PM an interview with Licensed | F0558 | | |

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| F0558 SS = D | Continued from page 2<br>Practical Nurse (LPN) #1 revealed she stated that she had been in the rooms of Resident #1 and Resident #4 and had not noticed that their call lights were out of reach. She confirmed it was important for residents to have their call bells in reach to summon assistance as needed. | F0558 | | |
| F0690 SS = E | Bowel/Bladder Incontinence, Catheter, UTI<br><br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br><br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, policy review and interviews, the facility failed to provide incontinent supplies and services for one (1) resident with indwelling urinary catheter (Resident #4) and for three (3) incontinent residents out of six (6) sampled | F0690 | | |

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| F0690 SS = E | Continued from page 3<br>incontinent residents, Residents #1, #2 and #3.<br><br>Findings include:<br><br>Policy review of the facility policy titled "Proper Techniques for Urinary Catheter Maintenance", undated, revealed the policy revealed, "…Do not rest the bag on the floor...Empty the collecting bag regularly, as a standard of practice at least every shift" The policy did not address necessity of physician's order for indwelling catheters.<br><br>Record review of the Incontinence Care Statement dated 10/27/25 signed by the facility Administrator revealed the facility "provides incontinence care and follows the audit tool"; the document did not address incontinence supplies.<br><br>Record review of the "Peri Care Audit Tool", undated revealed, "If Foley catheter present...maintains drainage".<br><br>Resident #1, #2 and #3 Incontinence supplies<br><br>On 10/20/25 at 9:10 AM the facility Ombudsman confirmed that she had received multiple complaints from Resident #1 and his Resident Representative and from other residents during October 2025 regarding the lack of incontinent supplies and postponed care due to residents having to wait for direct care providers having to wait for supplies to be provided for resident care. She stated that the Administrator had reported to her that there had been incidents of delayed delivery of supplies and supplies delivered to other facilities and not arriving at the facility.<br><br>On 10/20/25 at 11:08 AM during telephone interview the Resident Representative (RR) for Resident #1 revealed she had filed complaint with the State Agency (SA) due to events of October 2025 during which Resident #1 had telephoned or messaged her and reported that the staff had told him there were no more incontinence briefs in the facility. She said he was concerned and told her that he didn't want to have a bowel movement or request a change because the facility was out of briefs. She said she had instructed him to request assistance as needed with incontinence care. She stated that she had reported her concern to the facility's corporate hotline for concerns/complaints and had been told that there were problems with supply deliveries being late or sent to the wrong facility. She stated she had also reported this to SA on 10/02/25 after calling the facility and being told by staff that the facility was out of incontinence briefs. She could not provide the | F0690 | | |

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| F0690 SS = E | Continued from page 4<br>name of staff due to confidentiality concerns (she promised them she would not divulge their name).<br><br>On 10/20/25 at 1:25 PM during an interview with Resident #1 in his room revealed he said he had learned from Certified Nursing Assistants (CNA) (he was unable to provide the names of staff) on multiple occasions including Sunday, 10/19/25, that the facility was out of incontinence briefs. He stated that earlier in the month he had spoken with the Administrator and had been provided with a package of briefs initially placed on his nightstand and then moved to his closet and then removed from his room. Resident #1 stated that he had spoken with another member of management at the facility who had confirmed that “they were out of diapers”; he did not wish to provide the name of the staff member and said, “I don’t want to get her in trouble”. He said that he could not understand how the facility “ran out” of briefs with full knowledge that there were residents like him that required briefs for care. He said that on Sunday, 10/19/25 his care was postponed for at least an hour, and he was told that it was because there were no incontinence briefs available in the facility. Resident #1 stated that he was unable to transfer onto toilet or commode because he was not able to bear weight on his feet per physician’s orders. He said he was also unable to use bedpans.<br><br>On 10/20/25 at 2:25 PM during an interview CNA #3 confirmed that there had been shortage of incontinent care supplies for Resident #1 and other incontinent residents.<br><br>On 10/20/25 at 2:40 PM interview with CNA #2 revealed there had been times during October 2025 when she did not have access to incontinence supplies for certain sized residents. She said that management staff would go to local vendors and buy some, and that resident care was postponed waiting for the supplies to arrive at the facility.<br><br>On 10/20/25 at 2:52 PM a confidential interview with a direct care staff member who requested to remain anonymous, who SA confirmed was on duty on the 7:00 AM through 3:00 PM shift on 10/19/25, revealed there were no incontinent briefs available for resident care at approximately 8:00 AM through approximately 9:30 AM which resulted in lack of care or postponement of care for incontinent residents, including Resident #2 and Resident #3. The staff member stated that direct care staff had to wait for a member of the facility management staff to come to the facility with a key and unlock the supply closet for them to have access to incontinence briefs for the care of incontinent | F0690 | | |

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| F0690 SS = E | Continued from page 5<br>residents. The staff member stated that being low on supplies had caused issues for most of the month of October 2025. The staff member stated that low supply levels of incontinence supplies had been reported by themselves and other staff to the Assistant Director of Nurses (ADON) and the Administrator, and that even though there were times that the facility would purchase incontinence briefs from local vendors, the problem persisted. The staff member stated that there was not a problem with supplies at the time of survey (10/20/25) because a supply truck had delivered supplies at approximately 8:00 AM. She stated that she didn't offer information to residents that there were no incontinence briefs available, but she did not lie to them if they asked.<br><br>On 10/20/25 at 3:05 PM an interview with CNA #1 revealed she stated that the facility was not usually out of incontinence briefs but had “run out of certain sizes”. She stated that C.N.A.s were instructed to let the Director of Nurses, Assistant Director of Nurses or Administrator know if supplies were "low.<br><br>On 10/20/25 at 3:33 PM observation and interview with Resident #2 revealed she was waiting for requested incontinence care. She said she had returned from the therapy gym at approximately 1:00 PM and had not received any care since returning to her room. She stated she had notified CNA#4 at approximately 3:00 PM that she needed assistance with incontinence care. She said that she frequently had to wait for care, including incontinent care. She stated that on 10/19/25 she had to wait until approximately 10:00 AM and had been told by staff (she was unable to recall staff name) that the postponement of care was due to lack of supplies, specifically that there weren’t any incontinent briefs available. She stated that she had been told the same thing two or three times during the month of October 2025, but she was unable to recall dates other than Sunday, 10/19/25, and that there had been other times when she said, “I had to wear another size” because the facility was out of her size incontinence briefs. She reported that on the night of Saturday, 10/18/25 (she was unsure of the time), her CNA had brought in one (1) brief and told her that it was the last one available and on the morning of 10/19/25 she had been told that she would have to wait for care until supplies were available. She confirmed that her roommate was told the same thing.<br><br>On 10/20/25 at 3:45 PM interview with Resident #3 revealed she reported that she was frustrated by being told on Sunday, 10/19/25 that she had to wait for care until staff could obtain incontinence briefs needed for | F0690 | | |

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| F0690 SS = E | Continued from page 6<br>her care. She stated that she received no care on 10/19/25 until approximately 10:00 AM.<br><br>On 10/20/25 at 3:55 PM observation and interview with CNA #4 revealed she confirmed that she was assigned to the care of Resident #2 and Resident #3 and had not made rounds or provided any care for either Resident #2 or Resident #3 at 3:55 PM because she had to "straighten the cart and make someone's bed". She confirmed that Resident #2 had requested incontinence care at approximately 3:00 PM. She was unable to say how quickly incontinent care should be provided upon receipt of request for brief change due to incontinence but confirmed that the facility instructed CNAs to provide requested care in a timely manner, including incontinence care.<br><br>On 10/20/25 at 4:07 PM during an interview, the Administrator stated that on 10/16/25 the facility had purchased incontinent supplies from local vendors and that the nurses had a key to the rooms where the supplies were stored. She said she was not sure if the nurses understood that they had keys to the rooms, but that the nurses should have known that. She confirmed that she had been made aware of the issue of staff telling residents that the facility was low on or out of incontinence supplies, and that the facility had provided instructions for all direct care workers to notify the DON, ADON, or Administrator if there were any issues with supplies. She stated she was not aware that the facility had ever run out of incontinent briefs. The Administrator reported that incontinent briefs were purchased on 10/16/25 at approximately 5:30 PM from a local vendor to ensure the facility was stocked for the weekend. She said she considered an acceptable wait time for staff to gather equipment and return to a resident's room to provide requested incontinence care would be five to ten (5-10) minutes, possibly fifteen (15) minutes if there were some serious situation that required attention; she stated that she considered fifty-five (55) minutes too long for a resident to have to wait for requested incontinent care.<br><br>On 10/21/25 at 1:03 PM during an interview, CNA #5 stated that there was a constant shortage of incontinence briefs for resident care. She said she was on duty at the facility for the dayshift (7:00 AM to 3:00 PM) 10/19/25 and that she had texted the facility's Human Resource Coordinator (HRC) shortly prior to 8:00 AM and notified her that the CNAs needed incontinence briefs. She stated that incontinence care for incontinent residents was postponed for at least one and a half (1 ½) hours on the morning of 10/19/25 | F0690 | | |

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| F0690 SS = E | Continued from page 7<br>while direct care staff waited for the HRC to arrive with the key to unlock the storage room; she stated, “Everyone had to wait to get changed”. She said she didn’t know who else had a key to the storage room and she didn’t know if nurses had a key to the storage room. She said that the nurses were the immediate supervisors for the CNAs and supervised resident care.<br><br>On 10/21/25 at 1:20 PM during interview the facility HRC confirmed she received a text from CNA #5 on 10/19/25 at 7:43 AM that stated, “Need some briefs”. She stated that she arrived at the facility between 9:00 AM and 9:30 AM with the key to the storage room and unlocked the room and CNA #5 and other CNAs came and got incontinence briefs out of the closet. She stated that she was not sure if the nurses had a key to the storage room.<br><br>Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 8/22/25 with an Original Admission Date of 1/02/24 and the resident had diagnoses of diabetes end stage renal disease and dependence on renal dialysis.<br><br>Record review of the Quarterly Minimum Data Set (MDS) for Resident #1 with Assessment Reference Date (ARD) 10/14/25 revealed the resident had a Brief interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The MDS review revealed the facility assessed the resident could not walk, dependent on the use of wheelchair for mobility and required substantial/maximal assistance for toileting hygiene. The MDS review revealed the facility assessed the resident had occasional urinary incontinence and frequent bowel incontinence. The MDS review revealed the resident received dialysis.<br><br>Record review of the Admissions Record for Resident #2 revealed the facility admitted the resident on 4/01/25 and the resident had diagnoses of diabetes, neuropathy, and acute kidney failure.<br><br>Record review of the Quarterly MDS with ARD 10/09/25 for Resident #2 revealed the resident had a BIMS score of 15, which indicated no cognitive impairment. The MDS review revealed the facility assessed Resident #2 unable to walk 10 feet and dependent on wheelchair for mobility and required substantial/maximal assistance for toileting hygiene; toilet transfer was not attempted, and the resident did not perform this activity. The MDS review revealed the facility assessed the resident was always incontinent of bowel and bladder. | F0690 | | |

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| F0690 SS = E | Continued from page 8<br>Record review of the Admission Record for Resident #3 revealed the facility admitted the resident on 7/14/25 and the resident had diagnoses of chronic obstructive pulmonary disease, muscle weakness, lack of coordination, unsteadiness on feet, need for assistance with personal care, and cerebral infarction.<br><br>Record review of the Nursing Home Part A PPS Discharge MDS with ARD 9/22/25 for resident #3 revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment. The MDS review revealed the facility assessed the resident as dependent on staff for toileting hygiene and walking 10 feet with toilet transfer not attempted due to medical condition or safety concerns with continuous oxygen therapy.<br><br>Resident #4<br><br>On 10/21/25 at 12:25 PM observation and interview with Resident #4 revealed the resident's room smelled strongly of urine and there was a six (6) square foot area of the floor under and next to the resident's bed that was covered in urine which was dripping from a blue plastic urine bag cover. The resident said that the prior night shift nor the 10/21/25 day shift staff had emptied his urine collection bag.<br><br>On 10/21/25 at 12:39 PM interview in the room of Resident revealed the Maintenance Supervisor stated that the room smelled like urine.<br><br>On 10/21/25 at 12:40 PM observation and interview with the Administrator in Resident #4's room revealed she confirmed that Resident #4's room smelled like urine and that there was approximately seven (7) square feet of the floor beneath and beside the resident's bed that was covered with urine.<br><br>On 10/21/25 at 12:45 PM observation revealed the uncovered catheter urine collection bag was lying on the floor next to the Resident #4's bed along with the blue plastic urine collection bag cover, both were full to overflowing with urine. There was urine covering an eight square foot area of the floor beneath and next to the resident's bed, which was against the wall. The ADON and Wound Care Nurse emptied the urine collection bag into two (2) urinals and attempted to empty the blue plastic cover into a urinal and spilled an undeterminable amount onto the floor. Due to spillage the total amount of urine in the collection bag and the cover was not able to be determined. SA observed three (3) standard plastic 1000 milliliter (ml) urinals were filled from the collection bag and cover. | F0690 | | |

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| F0690 SS = E | Continued from page 9<br>On 10/21/25 at 1:03 PM CNA #5 stated that she had not noticed that resident #4's urine collection bag was full or overflowing or that there was urine under and beside his bed when she was in his room prior to 12:30 PM on 10/21/25. She confirmed that she had been in Resident #4's room and removed his lunch tray and clocked out for lunch; she stated that she did not smell urine in Resident #4's room because, "I can't really smell".<br><br>On 10/21/25 at 1:30 PM an interview with LPN #1 revealed she stated that she had not provided catheter care or checked to ensure catheter care was provided for Resident #4 on 10/21/25. She stated that the nurses were responsible for supervision of resident care. She stated that she had "glanced" at the indwelling catheter urine collection bag in it's blue cover and had not noted anything unusual or any problem with the drainage collection system between 12:00 PM and 12:30 PM. She stated that on 10/19/25 the HRC had reported to the facility and the storage room where incontinent briefs were stored and opened the room with a key at approximately 9:30 AM.<br><br>On 10/21/25 at 3:25 PM during interview the Corporate Nurse Consultant confirmed that there was no physician's order for indwelling catheter for Resident #4 and that if a resident had an indwelling catheter, they should have a corresponding order.<br><br>Record review of the Admission Record for Resident #4 revealed the facility admitted the resident on 9/12/25 and the resident had diagnoses of benign prostatic hyperplasia, need for assistance with personal care, urinary tract infection, and retention of urine.<br><br>Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/19/25 revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment. The MDS review revealed the facility assessed the resident as having an indwelling catheter.<br><br>Record review of the order Summary Report for Resident #4 revealed no physician's order for indwelling catheter. | F0690 | | |
| F0880 SS = E | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection | F0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIVERSICARE OF BROOKHAVEN | 519 BROOKMAN DRIVE , BROOKHAVEN, Mississippi, 39601 |

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| F0880 SS = E | Continued from page 10<br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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 | F0880 | | |

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| F0880 SS = E | Continued from page 11<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the facility staff failed to handle and transport linens in accordance with accepted standards in order to provide hygienically clean linens and prevent the spread of infection for one (1) of five (5) observations and failed to follow appropriate infection control practice for management of drainage system associated with indwelling catheter within accepted standards of practice for one (1) of six (6) sampled residents, Resident #4.<br><br>Record review of Facility History revealed the facility was cited 6/04/25 at level D for F880 for infection control due to improper handling of clean linen, therefore the scope and severity was increased to E.<br><br>Findings include:<br><br>Policy review of the facility policy titled, “DESCRIPTION OF STEPS IN THE LAUNDRY PROCESS”, Revision Date 10/25/16, revealed the policy stated, “Soiled Linen containers or barrels should be on each Nursing unit stored in a soiled area so that nursing can deposit soled linen…it is very important to properly transport and store soiled linens to prevent the spread of infection. To do so, all soiled linen and clean linen must be covered during transportation and while being stored”.<br><br>On 10/21/25 at 12:25 PM observation and interview with Resident #4 revealed resident’s room smelled strongly of urine and there was a six (6) square foot area of | F0880 | | |

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| F0880 SS = E | Continued from page 12<br>the floor under and next to the resident's bed that was covered in urine which was dripping from a blue plastic urine bag cover. The resident said that the prior night shift (11:00 PM 10/20/25 through 7:00 AM 10/21/25) nor the 10/21/25 day shift staff had emptied his urine collection bag. The resident stated that he had received treatment for urinary tract infection during his stay at the facility.<br><br>On 10/21/25 at 1:03 PM during an interview, C.N.A. #5 stated that she had not noticed that resident #4's urine collection bag was full or overflowing on 10/21/25 or that there was urine under and beside his bed when she was in his room prior at 12:25 PM on 10/21/25. She confirmed that she had been in Resident #4's room and removed his lunch tray and then clocked out for lunch; she stated that she did not smell urine in Resident #4's room because, "I can't really smell".<br><br>On 10/21/25 at 12:40 PM observation and interview with the Administrator revealed she confirmed that Resident #4's room smelled like urine and that there was approximately seven (7) square feet of the floor beneath and beside the resident's bed that was covered with urine, and the urine collection bag/bag cover were overflowing with urine dripping onto the floor.<br><br>On 10/21/25 at 12:45 PM observation revealed the uncovered catheter urine collection bag was lying on the floor next to Resident 4's bed along with the blue plastic urine collection bag cover, both were full to overflowing with urine. There was urine covering an eight square foot area of the floor beneath and next to the resident's bed, which was against the wall. The Assistant Director of Nurses (ADON) emptied the urine collection bag into two (2) urinals and attempted to empty the blue plastic cover into a urinal and spilled an undeterminable amount onto the floor. Due to spillage the total amount of urine in the collection bag and the cover could not be determined. SA observed three (3) standard plastic 1000 milliliter (ml) urinals were filled.<br><br>On 10/21/25 at 12:49 PM observation and interview revealed CNA #7 carried a two (2) foot tall stack of clean linen down the hallway clutched to her body/uniform. CNA #7 stated, "I forgot my bag, my bad". CNA #7 confirmed she was aware that it was important to cover linens during transport to carts/resident rooms to prevent the spread of infection.<br><br>On 10/21/25 at 1:00 PM interview with the Assistant Director of Nurses (ADON), who was the facility Infection Preventionist (IP), revealed she confirmed | F0880 | | |

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| F0880 SS = E | Continued from page 13<br>that it was important to cover linens during transport to carts/resident rooms to prevent the spread of infection. She confirmed that the nurses, she and the Director of Nurses (DON) supervised the care of residents and provision of care by the CNAs. She confirmed that nursing staff should monitor residents with indwelling urinary catheters and associated urine collection systems and the collection bags should be emptied as needed and not allowed to become full or overflowing.<br><br>On 10/21/25 at 2:00 PM an interview with the Administrator revealed she expected nurses and the ADON and DON to supervise the CNAs and care of residents, and that she expected the CNA.s to transport clean linens covered with disposable trash can liners supplied by the facility. The Administrator confirmed that she expected nursing staff to monitor residents with indwelling catheters and associated urine collection systems and meet the needs of those residents, including emptying the collection bags as needed.<br><br>Record review of the Admission Record for Resident #4 revealed the facility admitted the resident on 9/12/25 and the resident had diagnoses of benign prostatic hyperplasia, need for assistance with personal care, urinary tract infection, retention of urine, and heart disease.<br><br>Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/19/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS review revealed the facility assessed the resident as having an indwelling catheter. | F0880 | | |