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 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE , BROOKHAVEN, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 1/5/2025 through 1/8/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F658, F679, F812, F880. The facility had a census of 52 and was licensed for 58 beds.	F0000		
F0656 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 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	F0656		

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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F0656 SS = D	Continued from page 1 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, interviews, record reviews and facility policy review the facility failed to develop a comprehensive care plan regarding Post Traumatic Stress Disorder (PTSD) and for the use of oxygen (O2) therapy for two (2) of 20 care plans reviewed. Resident #2 and Resident #27. Findings include: A record review of the facility policy “Care Plan” with an effective date of October 2021 revealed “Care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines..." On 1/6/25 at 1:30 PM, in an interview Resident #2 stated she was in the Army for 34 years. She stated she fought in a war and that triggered her PTSD. She was very vague and would not talk much about it. She was talkative about other things. No behavior noted during interview. On 01/07/2026 at 2:40 PM, in an interview with Licensed Practical Nurse (LPN) # 1 stated residents have schizophrenia and get confused at times. She stated she is aware of PTSD and that should be on the care plan. On 01/08/26 at 12:18 PM, during an interview the Director of Nursing (DON) stated that the comprehensive care plan should contain details of PTSD, so staff will be aware when providing care. She stated this may help	F0656		

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F0656 SS = D	Continued from page 2 Resident #2 to calm down and let staff know what to avoid while providing care. On 01/08/26 at 12:34 PM, in an interview with Registered Nurse (RN) #1/Minimuum Data Set (MDS) nurse stated that the care plan is developed so that staff can use it while providing care. She stated the triggers for PTSD should be included in the care plan, it makes staff aware of the triggers of her PTSD. A record review of Resident #2's "Admission Record" revealed an admission date of 9/17/25 with diagnoses that included of Dementia in other diseases classified elsewhere, unspecified severity, with Mood Disturbance and Post-traumatic stress disorder, chronic which included an onset date of 9/16/25. A record review of the comprehensive care plans revealed a care plan for PTSD had not been developed. A record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed a Brief interview of Mental Status (BIMS) score of 9 which indicates moderate cognitive impaired. Resident #27 A record review of Resident #27's comprehensive care plan revealed there was not a care plan developed for oxygen usage. On 01/05/2026 11:32 AM, in an observation of Resident #27 in bed eating lunch. Resident #27 had O2 flowing at 2 milliliter (ml)/hour. On 01/05/26 at 11:35 AM, an interview with RN #2 confirmed that Resident #2 was receiving 02 at 2ml/minute. On 01/08/26 at 12:18 PM, during an interview the DON stated they do not have standing orders. She confirmed oxygen is a medication and should not be given without physician order. She stated the care plan should include oxygen so staff will know how to check saturation and tubing. She stated the care plan is used by all staff and should be correct. On 01/08/26 at 12:34 PM, in an interview with RN#1 care plan nurse stated if it is not on the physician orders there will not be a care plan developed. She stated it was not ordered. She stated all staff use care plans to give care. Record review of the "Admission Record" revealed	F0656		

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F0656 SS = D	Continued from page 3 Resident #27 was initially admitted on 7/9/2020 with diagnoses that included unspecified asthma. A record review of Resident #27's MDS with an ARD of 11/25/25 revealed a BIMS score of 14 which indicates the resident was cognitively intact. Record review of the "Order Summary Report" with active orders as of 1/6/26 revealed there was not a physician order for oxygen.	F0656		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews and facility policy the facility failed to obtain a physician order for oxygen (02) before administrating for one (1) of two (2) residents reviewed for oxygen. Resident #27 Findings include: A record review of the facility's "Oxygen Guideline" policy with an update of 8/1/24, revealed medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided in accordance with a healthcare provider's order and in accordance with acceptable standards of practice …" On 01/05/2026 at11:32 AM, in an observation of Resident #27 in bed eating lunch. Resident #27 has O2 flowing at 2 milliliters (ml). On 01/07/2026 at 8:20 AM, an observation of Resident #27 in bed oxygen flowing at 2ml. On 01/08/26 at 12:18 PM, in an interview, the Director of Nursing (DON) stated they do not have standing orders. She stated we call the Nurse Practitioner (NP) for all orders. She confirmed oxygen is a medication and should not be given without physician order. Record review of the "Admission Record" revealed Resident #27 was initially admitted on 7/9/2020 with	F0658		

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F0658 SS = E	Continued from page 4 diagnoses that included unspecified asthma. A record review of Resident #27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates the resident is cognitively intact. Record review of the "Order Summary Report" with active orders as of 1/6/26 revealed there was not a physician order for oxygen.	F0658		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to provide activities and invitations to activities to meet the residents' psychosocial needs for one (1) of 17 residents sampled. Resident # 19 Findings include: A review of the facility's policy, "Resident Rights and Quality of Life Policy", with an effective date of March 13, 2020, revealed, "…A patient or resident has a right…To receive services in a center environment that is…comfortable with adequate space for activities…" A review of the facility's "Recreation Services Assessment" dated 12/29/25 revealed the resident listed several activities that he would enjoy including Bingo. During an interview on 1/05/2026 at 11:15 AM, Resident #19 revealed he was new to the facility. The resident stated he was not interested in group activities but would like to participate in one-on-one activities. The Resident stated he has not been offered any opportunities for activities since moving into the	F0679		

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F0679 SS = D	Continued from page 5 facility. On 01/06/2026 at 9:40 AM, during an observation the Activities Supervisor (AS) walked from room to room inviting residents to the 10:00 AM activity. The AS walked past Resident #19's room without addressing the upcoming activity with him. On 01/06/2026 at 1:30 PM, an observation revealed the AS walked to and from multiple rooms on the hall to invite residents to 2:00 PM Bingo. The AS was observed to walk past Resident #19's room without addressing the upcoming Bingo activity. On 01/06/2026 at 2:45 PM, an interview with the resident confirmed he was not invited to any activity for the day. The resident stated he would have enjoyed playing bingo at 2:00 PM. The resident noted he would not be at the facility long because he is there for rehab, but he would like to be invited to activities. On 01/08/2026 at 9:21 AM, an interview with the AS acknowledged that she did not invite Resident #19 to activities that were tailored to meet his psychosocial needs. The AS noted that the purpose of encouraging residents to stay active, motivated and around people and to keep them cheerful. The AS noted she will improve her efforts to invite all the residents to activities and to document her efforts. During an interview on 01/08/2026 at 9:28 AM, the Administrator acknowledged that the resident has not received invitations to activities that were enjoyable to him. The Administrator affirmed the importance of keeping the residents engaged in activities. The Administrator noted that she will engage other staff to assist with inviting the residents to activities to ensure all residents are encouraged to join. A record review of the facility's "Admission Record" revealed the facility admitted the resident on 12/23/25 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact.	F0679		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812		

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F0812 SS = E	Continued from page 6 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to foods not dated, staff touching the garbage can lid and then touching clean dishes, touching food that is ready to eat with hands, staff touching their face then touching the food thermometer, placing used water pitchers back on the shelf with clean dishes during two (2) of (2) kitchen observations. Findings include: A review of the facility's policy, "Handwashing Procedure for Dining Services", undated, revealed "…situations that require hand hygiene…After handling soiled equipment or utensils…After…touching your…face…" A review of the facility's policy, "Food Storage: Cold Foods", revised 2/2023 revealed, "…Procedures…5. All foods will be stored…labeled and dated…" On 01/05/2026 at 10:08 AM, observation during an initial tour of the kitchen revealed Refrigerator #2 contained one (1) cup of what the Dietary Manager (DM) revealed to be thickened milk with no label or date.	F0812		

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F0812 SS = E	Continued from page 7 The DM acknowledged the unlabeled and undated milk in the refrigerator. The DM affirmed that the milk was not poured that morning. The DM reported that the milk should have been labeled and dated by the person who poured it to ensure it is used within a safe timeframe. On 1/07/2026 at 9:53 AM, during a second observation and interviews of the kitchen revealed during the food preparation the cook removed her gloves, lifted the garbage can lid with her bare hands, threw the glove in the garbage can and proceeded to remove clean dishes from the dishrack and place them in various shelves and drawers in the kitchen. The cook laid her hand across the top of each piece of cornbread with the spatula underneath as she lifted it from the cooking pan to be moved to another pan for the food service line. The Cook touched her mouth with her hand and proceeded to touch the thermometer used to check the temperature of the food. The Dietary Aide (DA) used two water pitchers to fill glasses, then placed the used pitchers back on the shelf with clean dishes. The Cook acknowledged touching the garbage can with her hand and then putting up the dishes. The Cook also acknowledged touching the cornbread with her hands to remove it from the pan and touching her mouth and proceeding to touch the thermometer. The Cook affirmed that she should have washed her hands and not touched the bread with her hands. The Cook stated the purpose of maintaining sanitation in the kitchen is to prevent the spread of germs. The DA acknowledged during an interview that she placed the pitchers back on the shelf with clean dishes. The DA stated the purpose of maintaining clean dishes is to prevent infection. The DM acknowledged the poor hand hygiene displayed by the kitchen staff and the placing of used dishes back among clean dishes. The DM stated the purpose of maintaining sanitary practices in the kitchen is to keep the elderly from getting sick and to keep down pathogens. The DM stated the staff has been in-serviced recently and will be in-serviced again. On 01/08/2026 at 9:50 AM, during an interview the Administrator acknowledged the unlabeled and undated milk as well as the unhygienic practices during the lunch service. The Administrator noted the importance of maintaining sanitary conditions in the kitchen is to prevent the spread of germs. The Administrator noted she expects the kitchen staff to adhere to the professional standards for sanitation.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = D	Continued from page 8 §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: §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	F0880		

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F0880 SS = D	Continued from page 9 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. §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 ensure infection control practices were followed during medication administration for one (1) of three (3) residents observed for medication pass (Resident #52). Findings include: Record review of the facility policy “Handwashing/Hand Hygiene” with an effective date of 11/1/2017 revealed “…2. All team members shall follow the handwashing/hand hygiene procedures…8. Single use disposable gloves should be used…b. When anticipating contact with blood or body fluids; and C. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions...” On 01/07/2026 at 8:10 AM, an observation of medication administration for Resident #52 was conducted with Licensed Practical Nurse (LPN) #1. During this time, the nurse was observed administering a nasal spray, an inhaler, and a lidocaine patch. LPN #1 entered the resident’s room and placed the medications on the bedside table without disinfecting the surface or applying a barrier to prevent contamination. At 8:12 AM, LPN #1 administered the nasal spray without wearing gloves, followed by the inhaler and the topical lidocaine patch—again without wearing gloves or performing hand hygiene between administrations. At	F0880		

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F0880 SS = D	Continued from page 10 8:18 AM, LPN #1 placed the used inhaler and nasal spray back into the unit's general medication cart without disinfecting them prior to storage. On 01/07/2026 at 8:20 AM, during an interview LPN# 1 confirmed she should have worn gloves to give the topical patch, but stated she did not know she was supposed to wear gloves when giving nasal sprays or inhalers. She then stated that she doesn't usually use a barrier when giving medications, but that they would help prevent cross contamination from occurring along with performing hand hygiene when changing between different routes of medication administration. She confirmed that items should not be placed on a resident's table and then back into a common area such as the medication cart without being disinfected first to prevent cross contamination. On 1/8/2026 at 10:48 AM, during an interview the Director of Nurses (DON) revealed that LPN# 1 should have performed hand hygiene, then placed gloves on before performing the inhaler medication administration, then changed gloves and completed hand hygiene before giving the nasal medication and then performed hand hygiene and changed gloves again prior to giving a transdermal patch. She noted that each medication required gloves to be worn to prevent infection. She stated that prior to sitting the resident's medications on the bedside table, it should have been disinfected. She further confirmed that items shouldn't be taken into a room, sat on a contaminated surface and then placed back in the medication cart without being disinfected properly. Record review of Resident 52's January 2026, Medication Administration Review (MAR) revealed medication administrations on 1/7/25 by LPN #1 as follows: 1).Azelastine-fluticasone 137-50 micrograms/actuation (mcg/act) 1 spray in both nostrils one time a day for allergic rhinitis. 2). Lidocaine 4% patch apply to affected area topically one time a day, remove after twelve hours. 3). Symbicort Inhalation Aerosol 160-4.5mcg/act 2 puff inhale orally twice a day. Record review of the "Admission Record" revealed Resident #52 was admitted to the facility on 7/3/24 with diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of Resident 52's Minimum Data Set (MDS) with an Assessment Reference date of 12/23/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.	F0880		