Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUCE COMMUNITY LIVING CENTER	**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
M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at facility from 2/17/26 through 2/19/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M620. The census at the time of the survey was 34 and the facility is licensed for 35 beds.	M0000		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, and record review, the facility failed to ensure a suprapubic catheter drainage system was maintained in a manner to promote proper drainage and prevent backflow of urine for one (1) of three (3) residents reviewed for catheters. Resident #12 Findings Include: Review of the education provided for skill competency catheter care titled “Urinary Catheter Care” dated 3/17/08 revealed, “When providing care for the resident who has a catheter there are some important guidelines for the caregiver to know. The drainage bag must be kept below the level of the bladder to prevent the backflow of urine. This can cause infection...” On 2/17/26 at 10:18 AM, an observation and interview with Resident #12 revealed he was sitting in his	M0620		

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

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M0620	Continued from page 1 wheelchair in his room with a urinary catheter drainage bag resting on the wheelchair seat beside him and not positioned below the level of the bladder. The resident stated the drainage bag would not remain attached to the lower part of the wheelchair and frequently fell off. The resident was later observed at 10:42 AM propelling himself in the hallway with the drainage bag remaining in the same improper position and no staff intervention to correct the placement. During an additional observation on 2/18/26 at 7:55 AM, Resident #12 was sitting in his wheelchair with the urinary drainage bag lying in the wheelchair seat and not below the level of the bladder. The resident was later observed at 8:45 AM propelling himself down the hallway with the drainage bag in the same position and no staff intervention to ensure proper drainage bag positioning. During an interview with Registered Nurse (RN) #1 on 2/18/26 at 9:06 AM, she confirmed Resident #12's catheter drainage bag was not being maintained in a manner to prevent backflow of urine. RN #1 stated this was the typical way the resident kept the drainage bag and acknowledged that backflow of urine could cause a urinary tract infection. On 2/18/26 at 3:20 PM, an interview with the Director of Nursing revealed staff were responsible for monitoring Resident #12's catheter drainage bag and ensuring it remained below the level of the bladder to prevent the potential for urinary tract infections. Record review of the "Admission Record" revealed Resident #12 was admitted on 8/19/24 with diagnoses including End Stage Renal Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/26 revealed under section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, and documented the presence of an indwelling catheter under Section H.	M0620		