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	43BM	A. BUILDING: _____ B. WING _____	C 08/31/2023

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DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI) ,at the facility from 8/29/23 through 8/31/23. 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. The SA investigated CI MS #22186 for resident abuse and cited M500. CI MS #22227 was investigated related to dietary services, quality of care related to treatment, resident abuse, and resident rights and M1020 was cited. No deficiencies were cited related to CI MS #22230 for quality of are related to incontinent care and accidents/falls.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his	M 500		10/3/23

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M 500	Continued From page 1 medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interview, record review,	M 500	The Administrator and Director of Nursing Services immediately ensured the safety and well being of the resident who was	

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M 500	Continued From page 4 and facility policy review, the facility failed to ensure that each resident was treated with respect as evidenced by staff using foul language in the presence of residents for one (1) of four (4) residents reviewed. Resident #1. Findings include: Record review of the facility policy "Resident Rights and Quality of Life," dated May 1, 2012, revealed, "Policy Statement: It is the policy of Advocat that all residents have the right to a dignified existence ..." On 8/29/23 at 9:00 AM, during a telephone interview with the facility ombudsman, he confirmed he had received notification of inappropriate speech with foul language by Certified Nursing Assistant (CNA) #1, during care of Resident #1. On 8/29/23 at 9:40 AM, during an interview with the Administrator, she revealed CNA #1 was using poor customer service and was cursing and used foul language in the presence of residents. She stated that CNA #1 had received disciplinary action prior to 7/20/23 and that CNA #1's employment at the facility had been terminated on 7/24/23. The Administrator further explained that on 7/20/23 CNA #1 was heard using foul language while propelling Resident #1 in the hallway near the nursing station but that she was not speaking to any resident. She stated it was like she was complaining out loud. She noted that following the report of the incident, Resident #1 was interviewed and assessed for physical or psychosocial harm and did not recall the incident. Record review of the "Progressive Discipline Form," for CNA #1, dated 6/4/21 revealed " ...First	M 500	present when allegation was made known accusing a staff member of using foul language in the center by removing the accused staff member from the facility. The Certified Nursing Assistant(CNA) was suspended 7/20/23 pending investigation and terminated 7/24/23. A body audit and emotional assessment performed by Director of Nursing on 7/20/2023 with no signs or symptoms of physical, mental or emotional distress noted. Resident #1 was interviewed by Director of Nursing Services on 9/01/2023 with no expression of verbal, mental or emotional distress noted. Resident had no knowledge of anyone using foul language in her presence while in the center. The Administrator immediately initiated an investigation into the allegation. State Agency and Attorney General's office was notified according to the required timelines 7/20/23 by Director of Nursing Services. The residents of the center have the potential to be affected if staff use foul language in their presence. Residents whom CNA had contact with, were interviewed by Social Service Director 7/21/2023 with no complaints or issues identified. Residents of the center , with Brief Interview for Mental Status (BIMS) 11 or greater, were interviewed 9/19/2023 by Assistant Director of Nursing Services and Social Services Director for knowledge of staff not adhering to resident's rights with no complaints or issues identified. Education initiated to staff on Resident's Rights, by Director of Nursing Services, Administrator and	

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M 500	Continued From page 5 Warning. ...Failure to treat a patient or resident with dignity and respect ... Inappropriate behavior/failure to adhere to (facility) Service Standards ..." Record review of the "Progressive Discipline Form" for CNA #1,dated 7/24/23, revealed a termination date of 7/24/23. The violation identified as the reason for the termination was listed as " ...Use of profane, abusive, or threatening language or unnecessary shouting ...Failure to treat a patient or resident with dignity and respect. The form revealed that a therapist had reported an incident in which she had observed CNA #1 coming out of a resident's room with the resident and stating, "I didn't take anyone's 'expletive' money. I don't need your 'expletive' money. I am so tired of this 'expletive' place". Record review of the "(Company Name) Personnel Change/Termination Form" dated 7/24/23 revealed ...Reason for Termination "Misconduct ..." On 8/29/23 at 10:05 AM, during an interview with the Occupational Therapist (OT) that reported the incident, she revealed that on 7/20/23 at approximately 2:30 PM, she witnessed CNA #1 propelling Resident #1 in the hallway past the nursing station and heard the CNA state "I didn't take anybody's 'expletive' money. I don't need your 'expletive' money. I'm so tired of this 'expletive' place!" The OT stated she had reported the incident to the Director of Nursing (DON). On 8/29/23 at 3:19 PM, an interview with the Resident Representative (RR) for Resident #1 revealed she had not noted any change in the	M 500	Director of Clinical Operations, Responsible Party notified, M.D. notified, Medical Director notified 7/20/23 by Director of Nursing Services. All staff in-serviced on Resident's Rights and Diversicare Service Standards including no use of foul language in the center by Director of Nursing Services and/or Administrator 9/01/2023. Resident's Rights reviewed with residents in Resident Council by Activities Director on 9/05/2023. To monitor the performance of our corrective action and to assure sustainability, the Administrator (ADM) and /or the Social Service Director (SSD) will interview 5 residents, with BIMS 11 or greater/week x 12 weeks beginning 9/4/2023. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 10/03/2023, by the ADM/SSD for review and revision as necessary.	

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M 500	Continued From page 6 behavior of Resident #1 since 7/20/23. On 8/31/23 at 9:00 AM, an observation and interview with Resident #1 revealed she was alert, able to communicate verbally and was oriented to self. She was unable to recall previous days or events. On 8/31/23 at 12:01 PM, an interview with the Social Worker revealed she reported that on 7/20/23 she observed CNA #1 rapidly propelling Resident #1 down the hallway but revealed she had been unable to hear anything that had been said. The Social Worker stated that she had observed Resident #1 since the incident and had not noted any change in behavior. On 8/31/23 at 6:14 PM, in a telephone interview with CNA #1, she revealed she did not understand why her employment at the facility was terminated. She stated she voiced her opinion and had spoken her mind, however, she denied that she cursed the resident or was abusive toward any resident in any way. She did not deny use of foul language in the hallway of the facility. She stated, "I am known for speaking my mind." Record review of the "Admission Record" for Resident #1 revealed that the resident was admitted by the facility on 4/27/23 and had diagnoses that included Dementia and Atherosclerotic Heart Disease. Record review of the Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 8/04/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had mild cognitive impairment.	M 500		

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M1020	45.35.3 Resident Bedrooms Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. All sweeping should be damp sweeping, all dusting should be damp dusting with a good detergent or germicide. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment for two (2) of four (4) residents reviewed Residents #3 and #4 Findings include: Record review of the (Formal Name of Environmental Services) "5-Step Daily Room Cleaning," undated, revealed, "PURPOSE: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility ...2. Horizontal Surfaces - disinfected *Using a solution of properly diluted germicide, sanitize all horizontal surfaces ...*Tabletops, headboards, windowsills, chairs, over bed lights, wall ledges, over bed tables, and the bases of over bed tables should all be done ... 4. Dust Mop... *Remember to dust mop and damp mop under beds... *When finished dust mopping, use a dustpan and brush to sweep up the debris. 5. Damp Mop... *The most important area of a patient's room to disinfect is the floor. This is where most airborne bacteria will settle and so it needs to be sanitized daily... *Mop all flooring surfaces... making sure to mop under the beds ..."	M1020	Resident room number C1 with sticky floor, debris on floor, dust in windowsill. No harm to residents #3 and #4 residing in C1. C1 was dusted, swept, and mopped by Housekeeping employee and Housekeeping Manager on 8/31/2023. C1 will be cleaned by Housekeeping staff twice per day beginning 9/01/2023. All residents residing in center has the potential to have environmental cleanliness opportunities. All rooms were reviewed by Administrator/ Housekeeping Manager for cleanliness and actions taken to ensure areas identified were cleaned by 9/21/2023.All Housekeeping employees were in-serviced by Housekeeping Manager on deep cleaning schedule, daily 5 and 7 step method to cleaning by 9/08/2023. Housekeeping Manager reviewed with return demonstration all housekeeping employees on daily 5 and 7 step method to cleaning by 9/08/2023. To ensure sustainability of our corrective action, Administrator or Manager On Duty will monitor 2 rooms on each wing 5 days/ week x 2 weeks beginning 9/04/2023 then	10/3/23

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M1020	Continued From page 8 Review of the policy titled "Resident Rights and Quality of Life," dated May 1, 2012, revealed, "Policy Statement: It is the policy of Advocat that all residents have the right to a dignified existence ...To receive services in a facility environment that is safe, clean, and comfortable ..." Resident #3 On 8/29/23 at 9:45 AM, an observation of Resident #3 in his room, revealed the windowsill of the room adjacent to the resident's bed was dirty. The windowsill was covered with dust. It was also noted that there were several pieces of brown debris scattered along the length of the windowsill. On 8/30/23 at 9:20 AM, observations of the rooms of Resident #3 revealed that the dust and debris noted the day before, remained in the windowsill in the resident's room. On 8/30/23 at 9:30 AM, an interview with the Resident Representative (RR) for Resident #3 revealed she was dissatisfied with the housekeeping at the facility and stated she frequently had to ask housekeepers to come into Resident #3's room to clean the floors or furniture or perform other housekeeping tasks. She commented that the floor was an ongoing issue because it was frequently sticky. On 8/31/23 at 9:55 AM, an observation of the windowsill adjacent to the bed of Resident #3 revealed dust and debris remained in the windowsill. Record review of the Admission Record for	M1020	3x/week x 10 weeks to ensure rooms are clean. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 10/03/2023 by the Administrator. QAPI will evaluate the findings of the QA to determine effectiveness of our corrective action and to determine need for changes.	

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M1020	Continued From page 9 Resident #3 revealed he was admitted by the facility on 12/29/22 and had diagnoses that included Alzheimer's Disease and Unspecified Dementia. Resident #4 On 8/29/23 9:47 AM, an observation of Resident #4's room revealed there was dust on the floor along the wall beside the resident's bed, with three (3) nickel sized round dried brown spots. On 8/30/23 at 9:20 AM, observation of the room of Resident #4 revealed that the dust and debris noted the day before, remained in the resident room. On 8/31/23 at 9:50 AM, an observation revealed in addition to the previously observed dust and dried brown substance noted on the floor along the wall and beside the bed of Resident #4, there was several pieces of dime sized white tissue paper strewn around the floor. There was a white facial tissue and a vinyl glove under the bed of Resident #4. The floor of the room was sticky. The floor was so sticky it caused the State Agency (SA)'s shoe to stick to the floor. On 8/31/23 at 10:05 AM an observation and interview with the Housekeeping Supervisor for the housekeeping contractor at the facility revealed the "usual" routine for housekeeping included daily cleaning of each resident room to include sweeping the entire floor (including beneath the beds), mopping the entire floor (including beneath the beds), and dusting flat surfaces (including the windowsill). He described this routine as was protocol and was to be done every day. He stated that the floor should not be sticky and that if it was it needed to be mopped with plain water and buffed. The Housekeeping	M1020		

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M1020	Continued From page 10 Supervisor described the floor along the wall adjacent to and beneath the bed of Resident #4 as dirty. He confirmed that the floor was sticky in places. Regarding the windowsill, the Housekeeping Supervisor stated, "there's negligence in cleaning, that is not unacceptable." He confirmed that it appeared to him that the floor under the resident's beds along the walls and the windowsill had not been cleaned in the past couple of days. He stated that the windowsill needed to be cleaned and the floor was sticky and needed to be mopped. On 8/31/23 at 11:10 AM, during an observation and interview with the Administrator in the room of Resident #3 and Resident #4, she confirmed the floor along the wall adjacent to the bed of Resident #4 and the windowsill adjacent to the bed of Resident #3 were "dirty" and the floor was "sticky". She stated that the floor needed to the "cleaned and mopped" and the windowsill needed to be cleaned. Record review of the Admission Record for Resident #4 revealed he was admitted by the facility on 12/09/22 and had diagnoses that included Atherosclerotic Heart Disease and Squamous cell carcinoma of skin of scalp and neck.	M1020		