STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations,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 requirements of participation in Medicare and Medicaid. The SA investigated CI MS #22186 for resident abuse and cited F550. CI MS #22227 was investigated related to dietary services, quality of care related to treatment, resident abuse, and resident rights F584 was cited. F584. No deficiencies were cited related to CI MS #22230 for quality of are related to incontinent care and accidents/falls. At the time of survey the facility had a census of 52 residents and was licensed for 58 beds.	F 000		
F 550 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	F 550		10/3/23

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

Electronically Signed | 09/21/2023

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F 550	Continued From page 1 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. §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 observation, interview, record review, 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	F 550	The Administrator and Director of Nursing Services immediately ensured the safety and well being of the resident who was 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	

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F 550	Continued From page 2	F 550		

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 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

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 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

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F 550	Continued From page 3 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 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	F 550	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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F 550	Continued From page 4 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.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		10/3/23

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F 584	Continued From page 5 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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	F 584	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	

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F 584	Continued From page 6 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 ..." 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.	F 584	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 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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F 584	Continued From page 7	F 584		

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 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.

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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 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

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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.