STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255324	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bruce Community Living Center	176 Highway 9 South Box 1280 Bruce, MS 38915

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on staff and resident interviews, record review, and facility policy review, the facility failed to consult with a cognitively intact resident about his Advance Directives, which resulted in a conflict between his documented preferences and his actual wishes for one (1) of sixteen (16) residents reviewed. Resident #6. Findings Included: Record review of the facility policy with reviewed date of ,d+[DATE] and titled, Advance Directives revealed The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so 5. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative An interview on [DATE] at 10:50 AM, with Resident #6 revealed that his brother signed the admission paperwork. He revealed that he didn't remember anyone discussing Cardiopulmonary Resuscitation (CPR) with him or asking him what his wishes were regarding resuscitation if he stopped breathing. Resident #6 confirmed that he did not know that his brother signed for him to be a DNR (Do Not Resuscitate). He confirmed that if he quit breathing, he wanted them to do CPR and everything they could to save him. An interview on [DATE] at 8:40 AM, with the Social Services Director (SSD) stated that Resident #6's representative signed the Code Status form marked DNR at the time of admission and confirmed that she did not discuss CPR options with Resident #6. The SSD revealed that Resident #6 was cognitively intact and should have been asked about his wishes. He should have made the choice and signed his own Advanced Directive. (continued on next page)

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 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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 8:45 AM, with the Administrator (ADM) confirmed that they were supposed to ask the residents about their code status choice and get them to sign if they were cognitively intact. She confirmed that Resident #6 was cognitively intact and capable of making his own decisions. ADM revealed that Resident #6 should have been asked about this choice and should have signed his own advanced directive on admission. Record review of Resident #6's Code Status form revealed that his representative initialed the Do Not Attempt Resuscitation choice and signed it on [DATE]. Record review of Resident #6's Physician Orders revealed an order effective [DATE] which revealed, Do Not Resuscitate in case of Arrest Record review of Resident #6's Admission Record revealed an admitted [DATE] with diagnoses that included Syncope and Collapse, End Stage Renal Disease, and Anemia. Record review of Resident #6's Care Plan revealed I am a DNR (Do Not Resuscitate) Record review of Resident #6's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that he was cognitively intact.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff interviews, record review, and facility policy review, the facility failed to provide written notification of discharge/transfer to the resident and/or resident representative (RR) upon transfer to the hospital for two (2) of two (2) residents reviewed for hospitalization . Resident #15 and Resident #30. Findings include: Review of the facility policy titled Notice of a Transfer and/or discharge date d February 26, 2003, revealed . 3. The resident, and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged . Resident #15 Record review of Resident #15's Progress Notes dated 8/2/24 revealed the resident was transported to the emergency room accompanied by two facility staff members. Record review revealed there was no transfer/discharge notification for Resident #15's transfer to the emergency roiagnom on [DATE]. Record review of Resident #15's Admission Record revealed that he was admitted to the facility on [DATE] with diagnoses that included a Personal History of Traumatic Brain Injury, and Hydrocephalus. Resident #30 Record review of the Progress Notes for Resident #30 revealed on 8/6/24 that the resident was transferred to the emergency room . Record review revealed there was no transfer/discharge notification for Resident #30's transfer to the emergency roiagnom on [DATE]. On 10/29/24 at 11:37 AM, an interview with the Administrator (ADM) revealed that the facility failed to mail a written transfer/discharge notification to the Resident Representative (RR) for both Resident #15 and Resident #30 when they were transferred to the hospital. An interview on 10/29/24 at 3:00 PM, the Social Services Director (SSD) confirmed she was unaware that a copy of the transfer/discharge notification was supposed to be mailed to the Resident's RRs, but she would make sure to get them sent out from now on. Record review of the Admission Record revealed the facility admitted Resident #30 on 07/25/24 with medical diagnoses that included Aphasia and Metabolic Encephalopathy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff interviews, record review, and facility policy review the facility failed to implement a comprehensive care plan for residents who required assistance with Activities of Daily Living (ADL) for two (2) of thirteen sampled residents. Resident #3 and Resident #4. Findings include: Review of the facility policy titled Care Plan - Comprehensive undated, revealed, Policy Statement: It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs .Procedure: 1. An interdisciplinary team, in coordination with the resident and his/her family or representative, develops and maintains a comprehensive care plan for each resident. Resident #3 A record review of Resident #3's care plan revealed, I have an ADL self-care performance deficit . Interventions/Tasks . Please shave when needed per my request . Check nail length and trim and clean on bath day and as necessary. On 10/28/24 at 10:50 AM, observation of Resident #3 revealed sporadic facial hair approximately one-half (1/2) inch long to the chin and above the upper lip and sides of her mouth. Fingernails on bilateral hands were approximately one-fourth (1/4) inch long and jagged past the tips of her fingers with a brown substance under the fingernails. On 10/28/24 at 4:40 PM, an interview and observation Registered Nurse (RN) #1 confirmed Resident #3's facial hair needed to be shaved, and her fingernails needed to be cleaned and filed. She confirmed the resident's ADL care plan was not being followed, and it should have been. In an interview on 10/29/24 at 10:10 AM, the Director of Nurses (DON) confirmed that Resident #3's ADL care plan was not being followed, and it should have been. During an interview on 10/30/24 at 11:46 AM, the Minimum Data Set (MDS) Coordinator revealed she and the team are responsible for developing the resident's individualized person-centered care plan. She revealed that when the residents were not being shaven and their nails cleaned and trimmed, then their ADL care plan was not being followed. She also revealed that everyone wants to look nice and neat, and the facility is responsible for ensuring this is being done. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Osteoporosis with current pathological fracture, and Paroxysmal Atrial fibrillation. 45598 Resident #4 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Care Plan revealed that she had an ADL self-care performance deficit with interventions that included checking nail length and trim and clean on bath day and as necessary. On 10/28/24 at 10:45 AM, observation and interview revealed Resident #4 lying in bed with long, jagged fingernails approximately one-half inch long past the tips of her fingers bilaterally with a brown substance underneath. Resident #4 also had two dime size patches of white curly hair on her left and right lower jaw area. On 10/28/24 at 4:35 PM, observation and interview with RN #1 confirmed that Resident #4's fingernails were long and jagged with a brown substance underneath and that she had facial hair. RN #1 revealed that nail care, shaving and oral care were all included in personal hygiene provided in the Care Plan and confirmed that since it was not done, then they did not follow the care plan. Record review of Resident #4's Admission Record revealed an original admitted [DATE] and diagnoses that included Peripheral Vascular Disease and Muscle Weakness. Record review of Resident #4's MDS with Assessment Reference Date (ARD) of 10/10/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that she had severe cognitive deficits.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident/family and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain hygiene, as evidenced by the failure to provide shaving and nail care for two (2) of the 27 residents reviewed. Resident #3 and Resident #4. Findings include: Review of the facility policy titled Shaving the Resident, with a revised date of August 25, 2014, revealed, The purpose of this procedure is to promote cleanliness and to provide skin care. Review of the facility policy titled A.M. Care (Day Tour of Duty) dated August 25, 2014, revealed Purpose: 1. To refresh the resident. 2. To provide cleanliness, comfort, and neatness. Resident #3 An observation of Resident #3 on 10/28/24 at 10:50 AM, revealed sporadic facial hair approximately one-half (1/2) inch long to the chin and above the upper lip and sides of her mouth. Fingernails on bilateral hands were approximately one-fourth (1/4) inch long and jagged past the tips of her fingers with a brown substance under the fingernails. During an observation and interview on 10/28/24 at 3:35 PM, Resident #3 was lying in bed with no change in appearance. Resident #3's sister was present in the room and revealed that she was sure her sister would like to have those facial hairs removed. An interview and observation on 10/28/24 at 4:20 PM, with the Certified Nurse Aide (CNA) #2 revealed hospice bathes the resident three days a week and the facility CNAs are responsible for the other days. She confirmed the resident's facial hair should have been shaven and her nails cleaned. In an interview and observation on 10/28/24 at 4:30 PM, with Licensed Practical Nurse (LPN) #1 revealed we've talked to the hospice staff several times about ensuring Resident #3's facial hair is shaved when they bathe her. She confirmed that the resident had long facial hair and her fingernails were jagged with a brown substance under them. She revealed that she was unsure how long it had been since the resident's facial hair had been shaved and stated, The resident needs to be cleaned up. In an interview and observation on 10/28/24 at 4:40 PM, Registered Nurse (RN) #1 revealed we are all responsible for making sure the resident is properly groomed; even though she is on hospice services. She stated they are ultimately responsible for ensuring the resident's facial hair is shaved, and her fingernails are clean and trimmed. RN #1 confirmed Resident #3's facial hair needed to be shaved, and her fingernails needed to be cleaned and filed. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Osteoporosis with current pathological fracture, and Paroxysmal Atrial Fibrillation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45598 Resident #4 An observation and interview on 10/28/24 at 10:45 AM, revealed Resident #4 lying in her bed with long, jagged fingernails, approximately one-half inch long past the fingertips bilaterally with brown substance underneath. Resident #4 also had two dime size patches of white curly hair on her left and right lower jaw area. She was pleasant and was fidgeting with her hair bonnet she held in her hands and when she was asked if she would like to have her facial hair removed, she stated, I think I would. An observation and interview with CNA #1 on 10/28/24 at 4:25 PM, revealed Resident #4 sitting up in her wheelchair across from the nurse's desk. CNA #1 confirmed that Resident #4 had long jagged fingernails with a brown substance underneath. CNA #1 also confirmed that Resident #4 had facial hair on both sides of her face that needed to be removed. CNA #1 revealed that it was the nurses' job to cut the fingernails, and the CNAs cleaned out from under the nails and took care of the facial hair. She revealed that Resident #4 was not assigned to her, but her nails should have been cleaned and her facial hair should have been removed during her bath or shower. CNA #1 revealed that long, jagged, dirty fingernails could cause infection if she scratched herself and stated, We can get that facial hair off. An interview on 10/28/24 at 4:35 PM with RN#1, confirmed that the nurses clipped resident fingernails, and the CNAs cleaned fingernails and shaved residents during their bath or shower time. RN #1 confirmed Resident #4 had long, jagged fingernails with a brown substance underneath and they should have been taken care of. She also confirmed the two patches of facial hair on both sides of Resident #4's face and agreed that this needed to be shaved. A phone interview with Resident #4's Resident Representative (RR) on 10/29/24 at 9:23 AM, revealed that he came to the facility and visited often. He revealed that the facility needed to do better about keeping her nails clipped. He also stated that he had noticed some facial hair and that she would want it to be removed. An interview on 10/29/24 at 10:20 AM, with the Director of Nursing (DON), revealed that seeing facial hair on ladies was one of her pet peeves and agreed that facial hair on ladies should be removed. She also confirmed that resident fingernails should be clipped and kept clean. Record review of Resident #4's Admission Record revealed an original admitted [DATE] and diagnoses that included Peripheral Vascular Disease and Muscle Weakness,. Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/10/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated that she had severe cognitive deficits. Section GG revealed that she required substantial to maximal assistance with her personal hygiene.