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	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, 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure notification of the Long-Term Care Ombudsman for one (1) of two (2) residents reviewed for discharge. Resident #40. Findings Include: Review of typed Statement dated 02/19/26 on facility letterhead, revealed that (proper name) facility did not have a policy to notify the local or state ombudsman of discharges to home. Record review of Resident #40's Physician Orders revealed an order dated 11/25/25 to D/C (Discharge) home today with (proper name) Home Health. Record review of Resident #40's Progress Note dated 11/25/25 revealed Resident #40 was propelled in wheelchair to private auto and transferred out of wheelchair into private auto with maximum assistance of one. No new orders noted. discharged to home with (proper name) Home Health. Record review of the facility's Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman for November 2025 revealed that Resident #40 was not included on the list of transfers/discharges completed for the month. An interview on 02/19/26 at 8:30 AM with Social Services Director (SSD), revealed that Resident #40 was admitted to the facility from the hospital in November 2025 with stroke-like symptoms. She revealed that she received therapy services and they discharged her home with home health services. SSD revealed that she did not send a notification of the discharge to the Ombudsman and did not know it was a requirement. She stated that she would get this fixed and that going forward, she would do so on all future discharges and transfers. Record review of Resident #40's admission Record revealed an admission date of 11/10/25 with diagnoses that included Cystitis and Generalized Muscle Weakness.

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on record review, staff interview, and facility policy review, the facility failed to notify the State Mental Health Authority of a change in mental health status for a resident with a diagnosed mental illness for one (1) of three (3) Pre-admission Screening and Resident Review (PASRR) records reviewed. Resident #2.Findings Include:Review of the facility policy titled Change in a Resident's Condition or Status latest review 08/2023 revealed under Policy Interpretation and Implementation.7. In addition to notifying the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition of a resident with a mental disorder or intellectual disability .Record review of the admission Record revealed the facility admitted Resident #2 on 4/29/25 with medical diagnoses that included bipolar disorder.Record review of Resident #2's Psychotherapy Progress Note dated 10/22/25 revealed, At approximately 11:05 AM, LCSW (Licensed Clinical Social Worker) met with the patient in her room to assess mood and safety after nursing staff reported signs of emotional distress. The patient was tearful, visibly upset, and expressed active suicidal ideation with both plan and intent. She stated, ?If I could, I would kill myself. I've been trying to figure out how to get cyanide pills. I just want to go be with my husband. I don't want to be here anymore.'Record review of Resident #2's Progress Notes dated 10/22/25 revealed the resident was transferred to a behavioral health facility for inpatient psychiatric services related to suicidal ideation.An interview with Social Services #1 on 2/18/26 at 9:30 AM revealed she was responsible for submitting status change referrals to the State Mental Health Authority. SS #1 stated she submitted status changes when a resident received a new mental illness diagnosis, a new psychiatric medication, or a medication change. SS #1 confirmed she did not submit a status change for Resident #2. She acknowledged the resident experienced worsening psychiatric symptoms and required inpatient psychiatric hospitalization in October 2025, which indicated a need for a status change submission to ensure the resident received required specialized services.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #2 was cognitively intact. Section I indicated a psychiatric diagnosis of bipolar disorder.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 .An observation and interview with Resident #12 on 2/17/26 at 10:18 AM revealed he was sitting in his 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.An additional observation on 2/18/26 at 7:55 AM revealed Resident #12 again 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.An interview with Registered Nurse (RN) #1 on 2/18/26 at 9:06 AM 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.An interview with the Director of Nursing on 2/18/26 at 3:20 PM 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 [DATE] 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.