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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Brookhaven	519 Brookman Drive Brookhaven, MS 39601

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 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** Based on observation, interviews, record reviews and facility policy review the facility failed to develop a comprehensive care plan regarding Post Traumatic Stress Disorder (PTSD) and for the use of oxygen (O2) therapy for two (2) of 20 care plans reviewed. Resident #2 and Resident #27.Findings include:A record review of the facility policy Care Plan with an effective date of October 2021 revealed Care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines .On 1/6/25 at 1:30 PM, in an interview Resident #2 stated she was in the Army for 34 years. She stated she fought in a war and that triggered her PTSD. She was very vague and would not talk much about it. She was talkative about other things. No behavior noted during interview.On 01/07/2026 at 2:40 PM, in an interview with Licensed Practical Nurse (LPN) # 1 stated residents have schizophrenia and get confused at times. She stated she is aware of PTSD and that should be on the care plan. On 01/08/26 at 12:18 PM, during an interview the Director of Nursing (DON) stated that the comprehensive care plan should contain details of PTSD, so staff will be aware when providing care. She stated this may help Resident #2 to calm down and let staff know what to avoid while providing care. On 01/08/26 at 12:34 PM, in an interview with Registered Nurse (RN) #1/Minimuum Data Set (MDS) nurse stated that the care plan is developed so that staff can use it while providing care. She stated the triggers for PTSD should be included in the care plan, it makes staff aware of the triggers of her PTSD. A record review of Resident #2's admission Record revealed an admission date of 9/17/25 with diagnoses that included of Dementia in other diseases classified elsewhere, unspecified severity, with Mood Disturbance and Post-traumatic stress disorder, chronic which included an onset date of 9/16/25.A record review of the comprehensive care plans revealed a care plan for PTSD had not been developed. A record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed a Brief interview of Mental Status (BIMS) score of 9 which indicates moderate cognitive impaired.Resident #27A record review of Resident #27's comprehensive care plan revealed there was not a care plan developed for oxygen usage.On 01/05/2026 11:32 AM, in an observation of Resident #27 in bed eating lunch. Resident #27 had O2 flowing at 2 milliliter (ml)/hour.On 01/05/26 at 11:35 AM, an interview with RN #2 confirmed that Resident #2 was receiving 02 at 2ml/minute. On 01/08/26 at 12:18 PM, during an interview the DON stated they do not have standing orders. She confirmed oxygen is a medication and should not be given without physician order. She stated the care plan should include oxygen so staff will know how to check saturation and tubing. She stated the care plan is used by all staff and should be correct. On 01/08/26 at 12:34 PM, in an interview with RN#1 care plan nurse stated if it is not on the physician orders there will not be a care plan developed. She stated it was not ordered. She stated all staff use care plans to give care.Record review of the admission Record revealed Resident #27 was initially admitted on [DATE] with diagnoses that included unspecified asthma.A record review of Resident #27's MDS with an ARD of (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/25/25 revealed a BIMS score of 14 which indicates the resident was cognitively intact.Record review of the Order Summary Report with active orders as of 1/6/26 revealed there was not a physician order for oxygen.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record reviews and facility policy the facility failed to obtain a physician order for oxygen (02) before administrating for one (1) of two (2) residents reviewed for oxygen. Resident #27Findings include:A record review of the facility's Oxygen Guideline policy with an update of 8/1/24, revealed medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided in accordance with a healthcare provider's order and in accordance with acceptable standards of practice .On 01/05/2026 at11:32 AM, in an observation of Resident #27 in bed eating lunch. Resident #27 has O2 flowing at 2 milliliters (ml).On 01/07/2026 at 8:20 AM, an observation of Resident #27 in bed oxygen flowing at 2ml.On 01/08/26 at 12:18 PM, in an interview, the Director of Nursing (DON) stated they do not have standing orders. She stated we call the Nurse Practitioner (NP) for all orders. She confirmed oxygen is a medication and should not be given without physician order.Record review of the admission Record revealed Resident #27 was initially admitted on [DATE] with diagnoses that included unspecified asthma.A record review of Resident #27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates the resident is cognitively intact.Record review of the Order Summary Report with active orders as of 1/6/26 revealed there was not a physician order for oxygen.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, record review and facility policy review the facility failed to provide activities and invitations to activities to meet the residents' psychosocial needs for one (1) of 17 residents sampled. Resident # 19 Findings include:A review of the facility's policy, Resident Rights and Quality of Life Policy, with an effective date of March 13, 2020, revealed, .A patient or resident has a right.To receive services in a center environment that is.comfortable with adequate space for activities.A review of the facility's Recreation Services Assessment dated 12/29/25 revealed the resident listed several activities that he would enjoy including Bingo.During an interview on 1/05/2026 at 11:15 AM, Resident #19 revealed he was new to the facility. The resident stated he was not interested in group activities but would like to participate in one-on-one activities. The Resident stated he has not been offered any opportunities for activities since moving into the facility.On 01/06/2026 at 9:40 AM, during an observation the Activities Supervisor (AS) walked from room to room inviting residents to the 10:00 AM activity. The AS walked past Resident #19's room without addressing the upcoming activity with him.On 01/06/2026 at 1:30 PM, an observation revealed the AS walked to and from multiple rooms on the hall to invite residents to 2:00 PM Bingo. The AS was observed to walk past Resident #19's room without addressing the upcoming Bingo activity. On 01/06/2026 at 2:45 PM, an interview with the resident confirmed he was not invited to any activity for the day. The resident stated he would have enjoyed playing bingo at 2:00 PM. The resident noted he would not be at the facility long because he is there for rehab, but he would like to be invited to activities.On 01/08/2026 at 9:21 AM, an interview with the AS acknowledged that she did not invite Resident #19 to activities that were tailored to meet his psychosocial needs. The AS noted that the purpose of encouraging residents to stay active, motivated and around people and to keep them cheerful. The AS noted she will improve her efforts to invite all the residents to activities and to document her efforts.During an interview on 01/08/2026 at 9:28 AM, the Administrator acknowledged that the resident has not received invitations to activities that were enjoyable to him. The Administrator affirmed the importance of keeping the residents engaged in activities. The Administrator noted that she will engage other staff to assist with inviting the residents to activities to ensure all residents are encouraged to join. A record review of the facility's admission Record revealed the facility admitted the resident on 12/23/25 with diagnoses including Chronic Obstructive Pulmonary Disease.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to foods not dated, staff touching the garbage can lid and then touching clean dishes, touching food that is ready to eat with hands, staff touching their face then touching the food thermometer, placing used water pitchers back on the shelf with clean dishes during two (2) of (2) kitchen observations.Findings include:A review of the facility's policy, Handwashing Procedure for Dining Services, undated, revealed .situations that require hand hygiene.After handling soiled equipment or utensils.After.touching your.face.A review of the facility's policy, Food Storage: Cold Foods, revised 2/2023 revealed, .Procedures.5. All foods will be stored.labeled and dated.On 01/05/2026 at 10:08 AM, observation during an initial tour of the kitchen revealed Refrigerator #2 contained one (1) cup of what the Dietary Manager (DM) revealed to be thickened milk with no label or date. The DM acknowledged the unlabeled and undated milk in the refrigerator. The DM affirmed that the milk was not poured that morning. The DM reported that the milk should have been labeled and dated by the person who poured it to ensure it is used within a safe timeframe.On 1/07/2026 at 9:53 AM, during a second observation and interviews of the kitchen revealed during the food preparation the cook removed her gloves, lifted the garbage can lid with her bare hands, threw the glove in the garbage can and proceeded to remove clean dishes from the dishrack and place them in various shelves and drawers in the kitchen. The cook laid her hand across the top of each piece of cornbread with the spatula underneath as she lifted it from the cooking pan to be moved to another pan for the food service line. The [NAME] touched her mouth with her hand and proceeded to touch the thermometer used to check the temperature of the food. The Dietary Aide (DA) used two water pitchers to fill glasses, then placed the used pitchers back on the shelf with clean dishes. The [NAME] acknowledged touching the garbage can with her hand and then putting up the dishes. The [NAME] also acknowledged touching the cornbread with her hands to remove it from the pan and touching her mouth and proceeding to touch the thermometer. The [NAME] affirmed that she should have washed her hands and not touched the bread with her hands. The [NAME] stated the purpose of maintaining sanitation in the kitchen is to prevent the spread of germs. The DA acknowledged during an interview that she placed the pitchers back on the shelf with clean dishes. The DA stated the purpose of maintaining clean dishes is to prevent infection. The DM acknowledged the poor hand hygiene displayed by the kitchen staff and the placing of used dishes back among clean dishes. The DM stated the purpose of maintaining sanitary practices in the kitchen is to keep the elderly from getting sick and to keep down pathogens. The DM stated the staff has been in-serviced recently and will be in-serviced again. On 01/08/2026 at 9:50 AM, during an interview the Administrator acknowledged the unlabeled and undated milk as well as the unhygienic practices during the lunch service. The Administrator noted the importance of maintaining sanitary conditions in the kitchen is to prevent the spread of germs. The Administrator noted she expects the kitchen staff to adhere to the professional standards for sanitation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure infection control practices were followed during medication administration for one (1) of three (3) residents observed for medication pass (Resident #52).Findings include:Record review of the facility policy Handwashing/Hand Hygiene with an effective date of 11/1/2017 revealed .2. All team members shall follow the handwashing/hand hygiene procedures.8. Single use disposable gloves should be used.b. When anticipating contact with blood or body fluids; and C. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions .On 01/07/2026 at 8:10 AM, an observation of medication administration for Resident #52 was conducted with Licensed Practical Nurse (LPN) #1. During this time, the nurse was observed administering a nasal spray, an inhaler, and a lidocaine patch. LPN #1 entered the resident's room and placed the medications on the bedside table without disinfecting the surface or applying a barrier to prevent contamination. At 8:12 AM, LPN #1 administered the nasal spray without wearing gloves, followed by the inhaler and the topical lidocaine patch-again without wearing gloves or performing hand hygiene between administrations. At 8:18 AM, LPN #1 placed the used inhaler and nasal spray back into the unit's general medication cart without disinfecting them prior to storage.On 01/07/2026 at 8:20 AM, during an interview LPN# 1 confirmed she should have worn gloves to give the topical patch, but stated she did not know she was supposed to wear gloves when giving nasal sprays or inhalers. She then stated that she doesn't usually use a barrier when giving medications, but that they would help prevent cross contamination from occurring along with performing hand hygiene when changing between different routes of medication administration. She confirmed that items should not be placed on a resident's table and then back into a common area such as the medication cart without being disinfected first to prevent cross contamination.On 1/8/2026 at 10:48 AM, during an interview the Director of Nurses (DON) revealed that LPN# 1 should have performed hand hygiene, then placed gloves on before performing the inhaler medication administration, then changed gloves and completed hand hygiene before giving the nasal medication and then performed hand hygiene and changed gloves again prior to giving a transdermal patch. She noted that each medication required gloves to be worn to prevent infection. She stated that prior to sitting the resident's medications on the bedside table, it should have been disinfected. She further confirmed that items shouldn't be taken into a room, sat on a contaminated surface and then placed back in the medication cart without being disinfected properly.Record review of Resident 52's January 2026, Medication Administration Review (MAR) revealed medication administrations on 1/7/25 by LPN #1 as follows: 1).Azelastine-fluticasone 137-50 micrograms/actuation (mcg/act) 1 spray in both nostrils one time a day for allergic rhinitis. 2). Lidocaine 4% patch apply to affected area topically one time a day, remove after twelve hours. 3). Symbicort Inhalation Aerosol 160-4.5mcg/act 2 puff inhale orally twice a day.Record review of the admission Record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease.Record review of Resident 52's Minimum Data Set (MDS) with an Assessment Reference date of 12/23/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.