STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI MS #22673) at the facility from 10/30/23 through 11/2/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F558, F580, F656, F688, F689, F812 and F880. The SA found the facility was not in compliance related to (CI MS # 22673) enviroment and Activities of Daily Living and cited F677 and F921. The census at the time of the survey was 125 and the facility was licensed for 140 beds.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		11/27/23

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

Electronically Signed | 11/22/2023

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to develop/implement care plans for (2) two residents related to shaving Resident #90 and Resident #173; failed to ensure a call light was in reach of (1) one resident, Resident #102; failed to consult a physician for medication changes for (1) resident, Resident #15; and failed to apply a splint for (1) one of (4) four residents reviewed with assistive devices, Resident #108; for a total of five (5) residents out of 26 sampled residents.	F 656	1. Resident #90 was shaved by assigned certified nursing assistant on 11/1/2023. On 11/8/2023, resident #90□s care plan was updated to reflect shaving. This resident was assessed by the Director of Nursing on 11/1/2023 and no negative outcome was noted for this resident. Resident #173 was discharged from facility on 10/31/2023 and we were unable to update his plan of care.	

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F 656	Continued From page 2 Findings include: A review of the policy titled, "Comprehensive Care Plans," revealed Policy: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #90 An observation on 10/30/23 at 11:25 AM revealed Resident #90 in wheelchair with long facial hair. Resident #90 stated he wanted to be shaved. An observation and interview on 10/31/23 at 4:38 PM with Resident #90 and Licensed Practical Nurse (LPN) #4, LPN #4 confirmed the resident stated he wanted to be shaved. Resident #90 stated he tried his best about a week ago to do it himself but just couldn't. An interview, on 11/1/23 at 11:30 AM with CNA #4 revealed that she was assigned to Resident #90 this morning. She stated that residents should be shaved on their shower days or as needed unless they refuse. She stated that when she saw Resident #90 this morning the hair on his face was "ridiculous" and that she shaved him first thing this morning. Review of the Admission Record resident information form revealed Resident #90 was admitted to the facility on 5/26/23 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left	F 656	Resident #102□s Call light was placed within reach of the resident on 10/30/2023 by certified nursing assistant as addressed in the resident□s care plan. Resident #102 was assessed by the Director of Nursing on 10/30/2023 and no negative outcome was noted for this resident. Resident #15 was assessed upon notification of increased blood sugar on October 31, 2023, by the Nurse Practitioner. Resident #15 did not have any adverse effects from the elevated Blood Sugar level. The Nurse Practitioner reviewed the resident□s treatment plan including the diabetic orders. On October 31, 2023, the Director of Nursing ensured that Diabetic Management protocol parameters were in place in accordance with out Diabetic Management guidelines for Resident #15. Resident #109□s hand was assessed on 11/1/2023 by the Director of Nursing. The resident□s hand was cleaned, and the Carrot (hand roll) was placed in her hand. The Nurse Practitioner was notified and visited 11/1/2023 Resident #109 to assess the affected hand. Resident #109 was referred on 10/31/2023 to Occupational therapy for evaluation and treatment. Resident #109□s care plan was reviewed and updated as needed at this time. 2. All residents who require shaving have the potential to be affected by this	

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F 656	Continued From page 3 dominate side, Anxiety disorder, Restlessness and Agitation, and Anemia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/23 revealed a Brief Review for Mental Status (BIMS) score of 12 which indicated Resident #90 had moderate cognitive impairment. Resident #173 An observation, on 10/30/23 at 1:20 PM revealed Resident #173 in bed, verbally unresponsive. Resident #173's spouse was at the bedside. She stated he has not been shaved since he was admitted. She stated the staff has not offered to shave him. Resident #173's spouse stated in the past Resident #173 always shaved his face except for a mustache. An interview, on 10/31/23 at 8:15 AM with the Director of Nursing (DON) revealed the staff should offer to shave residents, this was part of the resident's daily care. An interview, on 11/01/23 at 11:29 AM with Certified Nursing Assistant (CNA) #1 revealed when they give the residents a bath or shower, they should shave them if they have hair on their face. An interview, with the Licensed Practical Nurse (LPN) Minimum Data Set (MDS) nurse confirmed Resident #90 nor Resident #173 had an Activities of Daily Living (ADL) care plan for shaving. She stated that she thought everyone should know that shaving should be a part of bathing or showering. She confirmed it should be part of the care plan. The purpose of the care plan was to let	F 656	deficient practice. All residents have the potential to be affected by failing to keep the call light within reach. All residents who require a Carrot (hand roll) in their hands have the potential to be affected by this deficient practice. All residents were reviewed by the Director of Nursing on 11/03/2023 to ensure call lights were within reach of all residents. All residents were checked by the Unit Manager on 11/3/2023 to ensure if they needed shaved or assistance with shaving assistance it was provided. The Director of Clinical Operations reviewed all diabetics to assure that no other resident was affected by the negative practice on 11/13/2023. On 10/31/2023 all residents who required the use of a carrot was reviewed to ensure the carrots was in place by the Director Of Nursing. No Negative findings were found. 3. To ensure the deficient practice does not recur, The Director of Nursing or the Director of Clinical Operation will review all the residents care plans that require shaving by 11/21/2023 to ensure that shaving is added to their plan of care. The Administrator starting 11/3/2023 will assure that rounds are made throughout the day to assure that call bells are with in reach of each resident. The Director of Nurses, Assistant Director or Nurse or Unit Manager will round throughout the day to assure that resident who have orders for the use of a Carrot, have the Carrot in place in accordance with the plan of care. The Director of Clinical	

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F 656	Continued From page 4 staff know what care the resident should get. An interview on 11/02/23 at 8:57 AM with the DON revealed that care plans should be in place for resident's ADL care and stated the care plan should be in place to make sure appropriate care is provided to the residents and the care plan is the staffs' communication tool for resident care. Review of the Admission Record resident information form revealed the facility admitted Resident #173 on 10/17/23 with diagnoses that included Essential Hypertension, Acute Embolism and Thrombosis of Unspecified Deep Veins of left lower extremity, Cognitive Communication Deficit, and Diabetes Mellitus Type 2. Resident #102 An observation on 10/30/23 at 10:29 AM, revealed Resident #102's call light laying on the floor underneath the bed. A review of the care plan titled, "I am at risk for falls related to New environment, CVA (cerebral vascular accident) needing assist with transfer and bed mobility, impaired cardiovascular, dementia and psychotropic medication use," revised 10/31/23 revealed "Call light or personal items available and in east reach." An interview with the Minimum Data Set Nurse (MDS) on 10/31/23 at 3:19 PM confirmed after review of Resident #102's care plans, staff did not follow the care plan for keeping call light in reach and revealed the purpose of the care plan is direct resident specific care. The MDS nurse stated not following the care plan could lead to resident specific care needs not being met.	F 656	Operations provided education on 11/6/2023 to staff regarding the expectation that care plans will be developed and implemented including shaving, availability of call lights, notification of change related to blood sugar parameters and application of assistive devices. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 5 days a week for four (8) weeks and then weekly for 4 weeks to ensure that the nurses follow Diabetic Management guideline regarding notification of abnormal blood sugars starting 11/6/2023. The Unit Manager or Charge Nurse will audit all residents 5 days a week for 8 weeks, then weekly for 4 weeks starting 11/6/2023 to ensure their call lights are within reach. The Unit Manager or Charge Nurse will conduct Audits 5 days a week for eight (8) weeks and then weekly for 4 weeks starting 11/6/2023 to ensure that the residents who require shaving are shaved. The Director of Nursing or Nurse Assessment Coordinator will conduct audits on all residents with hand splints (carrots) to ensure they are in place and residents hands are clean (if applicable) and free from injury for 8 weeks and then weekly for 4 weeks starting 11/6/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with	

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F 656	Continued From page 5 Record review of the Admission Record revealed that the facility admitted Resident #102 to the facility on 12/06/22 with diagnoses Adult Failure to Thrive and Cerebral Infarction. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 9/28/23, revealed that Resident #102 had a Brief Interview of Mental Status (BIMS) score of 06 which indicated that she was severely cognitively intact. Resident #15 A record review of Resident #15's care plan, with an onset date of 6/20/23, revealed, Focus: "Resident's proper name" has Diabetes Mellitus with potential for complications...Interventions...If infection is present, consult doctor regarding any changes in diabetic medications... A record review of Resident #15's "Blood Sugar Summary" and Medication Administration Record (MAR) for October revealed that on 10/26/23 at 5:27 AM the resident's blood sugar was 466. A record review of October Physician orders revealed an order, with a start date of 10/25/23, for Macrobid Oral Capsule 100 milligrams (MG) give one (1) capsule by mouth two times a day for Urinary Tract Infection (UTI) for seven (7) days. During an interview on 11/1/23 at 3:00 PM, the Minimum Data Set Nurse (MDS) verified that Resident #15's care plan was not followed when the nurse failed to notify the Nurse Practitioner (NP) of Resident #15's blood sugar of 466. The MDS nurse stated failure to follow the care plan could lead to a delay in treatment.	F 656	November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 656	Continued From page 6	F 656		

A record review of Resident #15's Admission Record revealed that the resident was readmitted to the facility on 9/15/2022. Resident #15's active diagnoses included Type 2 Diabetes Mellitus and Urinary Tract Infection.

Resident #108

An observation/interview on 10/30/23 at 10:30 AM with Resident #108 confirmed that she was unable to open her left hand and that she could not move her left arm. The resident's left hand was contracted with her thumb pressed between the second and ring finger. There was no splint in Resident #108 left hand.

Record review of Care Plans for Resident #108 revealed a care plan initiated on 10/22/23 for a Restorative Splint/Brace program - "Place Carrot (hand roll) in hand as often as able to tolerate."

An interview, with Director of Nursing (DON) on 11/01/23 at 4:11 PM confirmed that the purpose of the care plan was to provide a structured means of providing care and communicating with other staff. The DON confirmed that failure to follow a care plan could result in providing the wrong care to a patient or not providing the care that the resident needs.

A review of the facility face sheet for Resident #108 revealed the facility admitted the resident on 3/08/23 with a diagnosis of Hemiplegia to left side, Contracture of left hand, Hyperlipidemia and Hypertension

A review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 8/23/23

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F 656	Continued From page 7 revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated Resident #108 was cognitively impaired.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and responsible party interview, and facility policy review the facility failed to provide activities of daily living (ADL) care, shaving, for two (2) of 125 residents reviewed on initial tour. Resident #90 and Resident #173 Findings include: Review of the facility policy title, "Activities of Daily Living (ADLs)", undated, revealed the facility will, based on the the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. The policy explanation and guidelines include a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #90 An observation on 10/30/23 at 11:25 AM revealed Resident #90 in wheelchair with a hard cervical collar in place and noted a long beard. Resident	F 677	F677 1. Resident #90 was shaved by his certified nursing assistant on 11/1/2023. On November 8th Resident□s #90 care plan was updated to reflect shaving. This resident was assessed by the Director of Nursing on 11/1/2023 and confirmed there were no negative effects of this deficient practice. Resident #173 was discharged from facility on 10/31/23 and we were unable to update his plan of care. 2. All residents who require assistance with shaving have the potential to be affected by this deficient practice. All residents were checked by the Unit Manager on 11/3/2023 to ensure if they needed shaved or assistance with shaving assistance, it was provided. 3. To ensure the deficient practice does not recur, on 11/6/2023 the Director of Clinical Education provided an in-service for all nursing staff on ensuring all residents who require assistance with shaving are shaved in accordance with	11/27/23

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F 677	Continued From page 8 stated he wants to be shaved. He stated that he tried to do it himself last week but just couldn't. An observation and interview, on 10/31/23 at 4:38 PM with Resident #90 and Licensed Practical Nurse (LPN) #1 confirmed the resident stated he wants to be shaved. Resident #90 stated he tried his best about a week ago to do it himself but just couldn't. LPN #1 told the resident he didn't have to do that because the staff should do that. An interview, on 11/1/23 at 11:30 AM with CNA #4 revealed that she was assigned to Resident #90 this morning. She stated that residents should be shaved on their shower days or as needed unless they refuse. She stated that when she saw Resident #90 this morning the hair on his face was ridiculous. She stated that she shaved him first thing this morning. Review of the Admission Record resident information form revealed Resident #90 was admitted to the facility on 5/26/23 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominate side, Anxiety disorder, Restlessness and Agitation, and Anemia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/23 revealed a Brief Review for Mental Status (BIMS) score of 12 which indicated Resident #90 had moderate cognitive impairment. Resident #173 An observation, on 10/30/23 at 01:20 PM revealed Resident #173 in bed, verbally unresponsive. Resident #173's wife was at the	F 677	the care plan. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct Audits 5 days a week for eight (8) weeks and then weekly for 4 weeks starting 11/6/2023 to ensure that the residents who require shaving are shaved. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 677	Continued From page 9 bedside. She stated they are good to bathe him, but he has not been shaved since he was admitted on 10/17/23. She stated the staff had not offered to shave him. Resident #173's wife stated he does wear a moustache but always shaved his face. An interview, on 10/31/23 at 8:15 AM with the Director of Nursing (DON) revealed the staff should offer to shave residents, and if they want to be shaved, they should do it. He stated that this was part of the resident's daily care. The DON stated all residents should be shaved if needed. An interview, on 11/01/23 at 11:29 AM with Certified Nursing Assistant (CNA) #1 revealed when they give the residents a bath or shower, they should shave them if they have hair on their face. Review of the Admission Record resident information form revealed Resident #173 was admitted to the facility on 10/17/23 with diagnoses that included Essential Hypertension, Acute Embolism and Thrombosis of Unspecified Deep Veins of left lower extremity, Cognitive Communication Deficit, and Diabetes Mellitus Type 2.	F 677		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		11/27/23

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F 921	Continued From page 10 Based on observation, staff interview, and facility policy review the facility failed to provide a safe/functional/sanitary/comfortable environment as evidence by a gray/black residue on a residents room wall and dirty air conditioner filter for three (3) of four (4) days of survey, for one (1) of 75 resident rooms observed. Resident #83 Findings Include: A review of the facility policy titled "Room Audit" Effective Date: September 1, 2014, revealed: Purpose - "To assess resident rooms to identify items that should be repaired, replaced, or addressed to ensure a home - like standard that meets acceptable standards. Guidelines: General Room Appearance - Housekeeping issues should be noted and reported to housekeeping. Damage drywall, furniture, or non-functioning equipment, etc. should be noted, a work order created and addressed according to priority." A review of the facility policy titled "Room Air Conditioner/Heating Units - PTAC" Effective Date: September 1, 2014. Guidelines: "Monthly Maintenance - Front Filters should be vacuumed and rinsed (replace when damaged). Front covers should be vacuumed with a soft brush attachment and cleaned with mild soap." An observation on 10/30/23 at 11:30 AM of Resident #83's room revealed duct tape noted to the top of the air conditioner. The front of the air conditioner was off and laying on the floor and the filter was covered with dust. There was an area of the wall on the right front corner, next to the air conditioner approximately 3 feet by one foot area with a gray/black residue on the wall.	F 921	F921 1. Resident #83 air conditioner was cleaned, the duct tape removed, and the cover replaced by the Maintenance Supervisor on 11/2/2023. The area noted next to the air conditioner three feet by one foot that was gray/black residue on the wall was cleaned by the maintenance Supervisor on 11/2/2023. 2. All residents have the potential to be affected by this deficient practice. The Maintenance Supervisor audited all residents□ rooms on 11/2/2023 to ensure the air conditioner filters were clean, free from duct tape and that covers were on the air conditioners properly. On 11/2/2023 the maintenance Supervisor also checked all rooms to ensure there was no gray/black residue on the walls of the resident□s room. 3. To ensure the deficient practice does not recur, on 11/2/2023 the Director of Clinical Education provided an in-service to staff on reporting air conditioners that require cleaning, duct tape that needs to be removed, and if air conditioner covers need to be replaced. They were also in serviced on reporting any areas noted next to the air conditioner or in the resident□s room that has gray/black residue on the walls. On 11/2/2023 the Corporate Nursing Home Administrator in-serviced the Maintenance Supervisor and the Maintenance Assistant regarding the cleaning and maintenance of the air conditioners, removing duct tape, and ensuring that air conditioner covers are in place. 4. To monitor the performance of our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	C 11/02/2023

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F 921	Continued From page 11 An observation, on 10/31/23 at 8:30 AM of Resident #83 room revealed, the area on the wall next to the air conditioner with the gray/black residue remains on the wall unchanged. The front cover of the air conditioner remained off and lying in the floor and filter remained dusty. An interview, on 10/31/23 at 9:41 AM with Licensed Practical Nurse (LPN) #1 confirmed the area of gray/black residue on the wall in Resident #83's room and the front cover of the air conditioner lying in the floor. LPN #1 confirmed the buildup of dust inside the air conditioner. LPN #1 confirmed that it needs cleaning and that if it's left like that it could possibly cause respiratory issues. An interview, on 10/31/23 at 10:00 AM with District Manager for Housekeeping confirmed the area of gray/black residue on the wall in Resident #83's room and the front cover of the air conditioner lying in the floor. The Housekeeping District Manager confirmed that it looks like a buildup of dirt, dust and water that blew out from the air conditioner and that they had cleaned it but it keeps coming back in the same spot. The Housekeeping Manager confirmed that if left there it could make the resident sick. An interview, on 11/02/23 at 10:00 AM with the Administrator, she confirmed there is a gray/black residue on the wall in Resident #83's room and the air conditioner filter needed cleaning and confirmed if left unclean it could result in a resident becoming sick. The Administrator also revealed that this area has been repaired for the same issue and it came back and confirmed there was an issue with a water leak in this area.	F 921	corrective action and to ensure sustainability the Social Workers and the Director of Clinical Coordination will audit to ensure that the air conditioners are clean, free of duct tape, air conditioner covers are in place and the walls in the resident□s rooms are free from any gray/black residue on the walls weekly for eight (8) weeks and then monthly for 4 weeks starting the week of 11/6/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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