| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255139 | A. BUILDING _____ B. WING _____ | 12/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIVERSICARE OF BATESVILLE | 154 WOODLAND ROAD BATESVILLE, MS 38606 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification at the facility from 12/04/23 through 12/07/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F554, F609, F625, F641, F644, F656, F677, F689, F692, and F758.<br><br>The facility held a license for 130 beds, with a census of 102. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to complete and document a resident self-administration of medications evaluation for one (1) of 1 resident reviewed for self-administration of medications. (Resident # 28)<br><br>Findings Include:<br><br>Record review of the facility policy revealed that the facility has adopted "Clinical Nursing Skills and Techniques, Perry & Potter" as supplementary policy and procedure. A record review of "Clinical Nursing Skills and Techniques, Skill 44.6, Teaching Medication Self-Administration" , page 1133 revealed | F 554 | 1. Resident #28 was assessed on 12/7/2023 by Registered Nurse. There were no negative findings. Resident #28 was assessed for capabilities to perform medication self administration safely with completion of self medication administration evaluation reflected in medical record on 12/7/2023. Care plan was updated on 12/7/23 to reflect resident desires to perform self medication administration and is able to safely perform.<br><br>2.All residents performing or desiring self medication administration in the facility are at risk for the deficient practice. | 1/4/24 |

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

Electronically Signed | 12/29/2023

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| F 554 | Continued From page 1<br>"Assessment ...2. Assess the client's cognitive, sensory, and motor function ...4. Assess client's learning readiness and ability to concentrate ...and learning style preference..."<br><br>During an observation of Resident #28's room and interview on 12/4/23 at 11:07 AM, revealed two (2) plastic vials laying on the overbed table. Resident #28 revealed that the 2 vials were her breathing treatment medications and she prefers to give herself the breathing treatment at a later time, so the nurses leave them for her.<br><br>During an observation and interview with Licensed Practical Nurse (LPN) #3 on 12/4/23 at 11:11 AM, she confirmed that the 2 plastic vials laying on Resident #28's overbed table were the medications for the resident's breathing treatment. LPN #3 stated that Resident #28 did not like to take the medications when they were due so she left them in the room so the resident could give them to herself when she was ready. LPN #3 verified the medications were Arformoterol Tartrate 15 micrograms (mcg) per two 2 milliliters (ml) and Budesonide 1 milligram (mg) per two 2 ml.<br>LPN #3 revealed that Resident #28 should have an evaluation and observation performed to make sure she could administer the medication herself and verified that Resident # 28 did not have a completed evaluation for self-administration of medications.<br><br>A record review of the facility evaluation forms for Resident #28 revealed no Self-Administration of Medication forms, dated prior to 12/3/23 (date of entry of State Agency).<br><br>During an interview on 12/5/23 at 3:25 PM, with | F 554 | 3. 100% audit of all residents by the interdisciplinary Team was completed on 12/8/2023 to identify any resident that desires to perform medication self administration. Any residents identified will complete evaluations an competences to ensure protocol is in place. Interview all direct care nursing staff was conducted by the Director of Nursing Services on 12/08/2023 to identify and missed opportunities with identifying residents wishing to self administer medications. Initiated 100% education with all nursing staff on 12/7/2023 by the Director of Nursing and Director of Clinical Education on the process of evaluation of medication self administration, competence check off with residents and notification to management of any residents wishing to self administer medication.<br><br>4. Interdisciplinary Team will perform audits on medication self administration of medication evaluations on all residents who self administer medication 12/7/2023 once weekly for 4 weeks, then monthly for two months. All new admissions will be reviewed for performing self medication administration during daily clinical start up meeting beginning on 12/8/2023. This will be discussed and documented in Quality Assurance and Performance Improvement. The deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times 3 months. Any variance to procedure will be corrected immediately | |

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| F 554 | Continued From page 2<br>the Director of Nursing (DON) she stated that if the resident expressed that they wanted to self-administer their medication an evaluation is completed. She stated the resident's Brief Interview for Mental Status (BIMS) score is checked to make sure the resident can understand how to self-administer medications and an observation of the resident administering the medication is performed. The DON revealed if the resident meets the criteria, they can self-administer the medication. The DON stated that she had been told, that in the past, Resident #28 preferred to self-administer her breathing treatments.<br><br>During an interview with the DON on 12/7/23 at 8:10 AM, she verified that Resident #28 did not have a Self-Administration of Medication evaluation completed prior to 12/4/23 at 11:59 AM and agreed that she should have already had one.<br><br>A record review of Resident #28's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/13/23, revealed a BIMS score of 15, indicating that the resident is cognitively intact.<br><br>A record review of the Admission Record for Resident #28 revealed that the resident was admitted on 3/7/2017, with diagnoses that include Chronic Obstructive Pulmonary Disease and Malignant Neoplasm of Right Main Bronchus. | F 554 | and addressed by IDT. | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility | F 609 | | 1/4/24 |

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| F 609 | Continued From page 3<br>must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, staff interview, record review and facility policy review the facility failed to report an accident involving the transport van which resulted in a major injury to a resident for one (1) of 34 sampled residents. Resident #66<br><br>Findings include:<br><br>Review of the facility "Event Communication Pathway" dated August 2021, revealed a yellow event is managed by the RVP/DCO (Regional | F 609 | 1. Allegation of Neglect on Resident #66 was reported on 12/21/2023 by the Administrator.<br><br>2. All Residents residing in the center have the potential to be affected.<br><br>3. Education was conducted on Abuse and Neglect reporting requirements to the Administrator by Director of Clinical Operations on 12/21/2023 to ensure all | |

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| F 609 | Continued From page 4<br>Vice President/Director of Corporate Operations) and the center leadership. Examples of yellow events include but are not limited to the following: Injury related to equipment.<br><br>Review of the "Event Response" procedure included under communication and documentation: Collaborative determination of state reporting requirements.<br><br>During an interview on 12/04/23 at 1:15 PM, Resident #66 stated that she was in an accident in the facility van a few months ago and suffered a fractured leg. She stated she did not remember talking to anyone from the state about it. She stated that her wheelchair was secured in the van, but the shoulder strap/seatbelt was not working, so she did not have it on and when the driver made a sudden stop, she fell out of the wheelchair.<br><br>An interview, on 12/5/23 at 10:30 AM with the Administrator (ADM) confirmed that she did not report the incident to the state agency because the resident was not on the premises when it occurred. She looked at it as a motor vehicle accident.<br><br>An interview, on 12/06/23 at 9:03 AM, with the ADM confirmed that she did not feel she needed to report this incident to the state because the resident was alert and oriented and able to tell what happened and the van driver told her what happened. The ADM did agree that the issue was the facility did not secure the resident properly in the van and that is why it should have been reported because Resident #66 suffered a major injury as a result. | F 609 | alleged violations are to be reported to State Agency in a timely manner. Education was conducted on Abuse and Neglect on 10/09/2023 when the incident occurred by the Director of Clinical Education.<br><br>4.Administrator or team member will monitor for any alleged violations in the form of resident and staff interviews beginning 12/7/2023 daily for four weeks and then weekly for 2 months to ensure ongoing and sustained compliance with this alleged violation. Any adverse findings will be immediately reported to the Administrator. Investigated and reported to the state agency as deemed necessary. Any Variance to procedure will be corrected immediately and addressed by the Administrator. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |

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| F 609 | Continued From page 5 | F 609 | | |

Record review of the Incident Report Form revealed, "Date of incident: 10/09/2023, Approximate time of incident: 4.00 PM Location of incident: ...Hwy 7 of Greenwood, MS while being transported per facility van from a scheduled appointment ...Resident fell face forward to the floor out of the wheelchair in the facility van when driver made a fast stop ... (Proper Name of Resident #66) experienced a fall while seated in her wheelchair on the facility van. Resident was transported by EMS (emergency medical services) to local ER (emergency room). X rays were obtained. (Proper Name of Resident #66) has a broken leg ..."

Record review of the History and Physical from the emergency room (ER) visit dated 10/9/23 revealed, "Admitting Diagnosis: Femur fracture ...MVA (motor vehicle accident) ...in a nursing home van in a wheelchair we had a sudden break was applied and she was thrown out of her wheelchair and sustained deep laceration to left shin, EMS (emergency medical services) was called and they reported large amount of blood on scene and she was hypotensive. In the ER she was given IV (intravenous) fluids with improvement in blood pressure ...Of note patient is on Eliquis (blood thinner) ...x-ray left femur showed comminuted impacted distal femoral metaphyseal fracture ..."

Review of the Admission Record revealed Resident #66 was admitted to the facility on 11/10/22 with diagnoses that included unspecified Osteoarthritis, Muscle Weakness, Abnormal Posture, and Nondisplaced Comminuted Fracture of Shaft of Left Femur.

Review of the Minimum Data Set (MDS) with an

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| F 609 | Continued From page 6<br>Assessment Reference Date (ARD) of 10/23/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #66 was cognitively intact. | F 609 | | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, family and staff interview, | F 625 | 1. Business Office Manager was | 1/4/24 |

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| F 625 | Continued From page 7<br>record review and facility policy review the facility failed to provide written notification to the resident or resident representative regarding bed hold when the resident was sent to the hospital for an evaluation for two (2) of five (5) residents reviewed for hospitalization. Residents #74 & #28<br><br>Findings include:<br><br>A record review of the facility policy "Bed Hold Policy", with an effective date of 11/1/2016, revealed "Procedure 1. Before the Center transfers a Resident to a hospital or the Resident goes on therapeutic leave, the Center shall provide Resident or his or her Resident Representative this Bed Hold Policy."<br><br>Resident #74<br><br>Record review of the facility general notes for 11/8/23 at 9:45 AM revealed Resident #74 was sent out to the hospital for evaluation related to Altered Mental Status.<br><br>Record review revealed no evidence of the bed hold form for Resident #74 in the computer.<br><br>An interview on 12/07/23 at 9:45 AM, with the Business Office Manager revealed she was able to produce a bed hold for Resident #74. She confirmed the form did not include the start date for bed hold payment to begin. She stated that they send the bed hold forms by mail and scan a copy but Resident #74's form had not been scanned yet.<br><br>On 12/07/23 at 9:49 AM, a phone interview with Resident #74's Resident Representative (RR) revealed that she got the transfer to the hospital | F 625 | in-service on the current bed hold policy on 12/7/2023 by the Administrator. A review of all residents was completed on 12/8/2023 by the Business office Manager and Administrator that the bed Hold policy was being followed according to facility policy and procedures.<br><br>2. All residents in the center could be affected by not following the bed hold policy.<br><br>3. Monitoring and audits of the bed hold process will be done by Administrator, Business office Manager, or team member beginning 12/08/2023. All residents leaving the facility for medical reason or personal will be reviewed by interdisciplinary team during daily clinical Start UP meeting beginning on 12/8/2023 to ensure the bed hold policy process is completed.<br><br>4. Administrator or team member began monitoring the bed hold process on 12/08/2023 weekly for four weeks. Then monthly for three months. Any Variance to procedure will be corrected immediately and addressed by the Administrator. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |

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| F 625 | Continued From page 8 | F 625 | | |

form in the mail but did not get a bed hold form.

Review of the Admission Record for Resident #74 revealed a facility admission date of 9/22/23 with diagnoses that included Unspecified Dementia and Essential Hypertension.

Review of the Minimum Data Set (MDS) with an Advanced Reference Date (ARD) of 11/16/23 revealed a Brief Interview for Mental Status (BIMS) score of four (4) which indicated Resident #74 had severe cognitive impairment.

Resident #28

During an interview on 12/4/23 at 11:07 AM Resident #28 stated that she has never received a bed hold notification when transferred to the hospital. Resident #28 stated she is her own Responsible Party (RP).

Record review of the Bed Hold Request Form for Resident #28 dated 10/22/23 reveals "Resident is her own RP and staff was unsuccessful attempting to notify the resident by phone".

Record review of the Bed Hold Request Forms for Resident #28 dated 1/30/23, 2/27/23, and 3/4/23 revealed they were mailed. There was no indication of what address the forms were mailed to.

An interview with the Business Office Manager on 12/6/23 at 9:14 AM, she verified that she did attempt to contact the Resident #28 via phone

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| F 625 | Continued From page 9<br>while she was in the hospital on 10/22/23, but she was unable to reach her. She verified that she did not make any further attempts to notify Resident #28 of the bed hold policy.<br><br>During an interview with the Business Office Manager on 12/6/23 at 10:34 AM, she was unable to indicate where Resident #28's Bed Hold Notices were mailed and did not have proof of the documents being mailed.<br><br>During an interview with the Administrator on 12/6/23 at 10:36 AM, she verified that there was no documentation that Resident #28 ever received her bed hold notifications.<br><br>A record review of Resident #28's Minimum Data Set Assessment (MDS) with and Assessment Reference Date (ARD) of 10/13/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact.<br><br>A record review of the Admission Record for Resident # 28 revealed that the resident was admitted on 3/7/2017, with diagnoses that include Chronic Obstructive Pulmonary Disease and Malignant Neoplasm of Right Main Bronchus. | F 625 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and facility policy review, the facility failed to | F 641 | 1. Preadmission Screening and Resident Review Screening Review Level 2 was | 1/4/24 |

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| F 641 | Continued From page 10<br>accurately code the Minimum Data Set (MDS) assessments for three (3) of 28 assessments reviewed. Resident #3, Resident #13 and Resident #99<br><br>Findings include:<br><br>Review of the facility policy titled, "RAI (Resident Assessment Instrument) Process Guideline" dated September 2020, revealed " ...Process: ...All items on the MDS are to be coded per the instructions of the CMS (Centers for Medicare and Medicaid Services) Long-Term Care Facility Assessment User's Manual MDS 3.0 ..."<br><br>Resident #13<br><br>A record review of Resident #13's Admission Record revealed an initial admission date of 09/24/2021 and his medical diagnoses included Schizophrenia, Unspecified, with onset date of 08/14/2021.<br><br>Record review of Resident #13's Annual MDS with Assessment Reference Date (ARD) of 09/22/2023 revealed Section A 1500 coded as "No", Is the resident currently considered by the state level II PASARR (Pre Admission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition?<br><br>Record review of Resident #13's Annual MDS with ARD of 09/22/2023 revealed Section I, Active Diagnoses, was marked 16000 Schizophrenia (e.g., schizoaffective, and schizophreniform disorders).<br><br>Record review of "Summary of Findings Report" | F 641 | completed on 12/26/2023 on Resident #13, and Resident #3 by Social Services Director. Modification will be done once results have been received from State Designate Authority. Minimum Data State for Resident #99 was modified on 12/07/2023 by Registered Nurse Assessment Coordinator.<br><br>2. All Residents with coded with a Preadmission Screening and Resident Review (PASSAR) Level II are at risk for the deficient Practice.<br><br>3. 100% audit completed on 12/26/20223 of current Residents with PASARR Level II documentation to determine any coding discrepancies by Registered Nurse Assessment Coordinator and Social Worker Director. No additional discrepancies were found and no other modifications required. Registered Nurse Assessment Coordinator (RNAC) education provided on 12/07/2023 for coding PASSAR Level II on Modification of Minimum Data Set per Resident Assessment Instrument (RAI) Guidelines per Clinical Reimbursement Specialist.<br><br>4.Director of Nursing, RNAC, and Assistant Director of Nursing (ADNS) will monitor 5 assessments each week beginning 12/07/2023 for four weeks, then five assessments monthly for two months to identify any inaccuracy in PASSAR Level II coding. PASSAR Level II received from State Designated Authority be reviewed in Daily clinical Start up. The Deficient practice and the implemented | |

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| F 641 | Continued From page 11<br>dated 11/20/2013 under "Mental Health" was documented that "The individual meets criteria for having a diagnosis of mental illness as defined by PASARR .... Axis I primary: Schizophreniform Disorder.<br><br>Resident #99<br><br>A review of progress notes for Resident #99 dated 11/13/23 revealed, "Resident d/c (discharged) home with RP (Responsible Party) (Proper Name) at 1705 (5:05 PM)." ...<br><br>Review of the Discharge MDS with ARD of 11/13/23 Section A for Resident #99 revealed, A1805: Entered From: was coded 01. "Home/Community" ... A2105: Discharge Status: was coded 04. "Short-Term General Hospital."<br><br>An interview with the MDS Registered Nurse (RN) on 12/07/23 at 8:20 AM, she verified after review of Resident #99's Discharge MDS that Section A entered from and discharge status was coded incorrectly and confirmed Resident #99 entered the facility from the hospital not home as coded and was discharged home and not to the hospital.<br><br>Review of the Admission Record revealed the facility admitted Resident #99 on 10/05/23 with a diagnosis of Dislocation of Internal Left Hip Prosthesis and was discharged 11/13/23 home.<br><br>Resident #3<br><br>A record review of Resident #3's MDS with an ARD of 4/12/23 revealed "A 1500 Is the resident | F 641 | plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. Any variance will be corrected immediately by the Registered Nurse Assessment Coordinator. | |

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| F 641 | Continued From page 12 | F 641 | | |

currently considered by the state Level II PASARR process to have serious mental illness and/or intellectual disability or a related condition?" coded as "No". Section I Active Diagnoses revealed Anxiety Disorder, Bipolar Disorder and Schizophrenia were checked.

A record review of Resident #3's PASARR Determination, dated July 26, 2013, revealed that the PASARR Level II Determination was approved with recommendations.

An interview with the MDS RN on 12/5/2023 at 2:35 PM, she stated that she has been responsible for coding A 1500 of the MDS. The MDS RN stated she was not aware that Resident #3 had a PASARR Level II when she coded the MDS. She stated that Level II's were not uploaded in the electronic record. She agreed that if the resident had had been identified as having a mental illness by the state Level II PASARR it should have been coded on the MDS. She also agreed that the purpose for accurate coding of the MDS was to ensure the resident was receiving the appropriate interventions.

An interview with the Administrator on 12/5/23 at 2:40 PM, she stated that she was aware that some of the older documentation had not been uploaded in the computer system. The Administrator agreed that it was her expectation that the MDS nurses would have access to the information they needed to correctly code the MDS.

A record review of the Admission Record for Resident #3 revealed that he was admitted to the facility on 4/23/2022 with diagnoses that include Schizoaffective Disorder and Bipolar Disorder.

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| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review, the facility failed to submit a change in status referral for a Level II resident review for a resident who was hospitalized for a psychiatric condition which resulted in orders for an additional psychotropic medication for one (1) of seven (7) residents reviewed for Pre-Admission Screening and Resident Review (PASARR). (Resident # 3).<br><br>Findings Include:<br><br>Review of a statement on facility letterhead signed by the Administrator and undated revealed, "PASSAR .(Proper Name of Facility) follows the Mississippi Division of Medicaid's PASARR requirements as attached." Record | F 644 | 1. A Preadmission Screening and Resident Review Level 2 Referral was completed and submitted 12/22/2023 on Resident #3.<br><br>2. All Residents with a diagnosis of or history of a serious mental disorder in the center are at risk for the deficient practice.<br><br>3.100% audit conducted on 12/8/2023 by the Interdisciplinary Team of all resident's with diagnosis requiring a PASARR Level 2. No other discrepancies were identified in audit. Interdisciplinary team will review all newly admitted and readmitted resident diagnosis and all significant changes in | 1/4/24 |

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| F 644 | Continued From page 14<br>review of the attached document, titled "Mississippi PASARR Identifying Status Change" revealed ..." User's Manual provides guidance ...of Potential Change in Status indicators which may ...require submission of a Resident Review (Status Change in MS). This includes but is not limited to, residents previously identified by PASRR to have mental illness ...who:<br>Demonstrate increased behavioral, psychiatric, or mood-related symptoms.<br>Have behavioral, psychiatric, or mood related symptoms responsive to ongoing treatment ..."<br><br>Record review of Resident #3's Progress Note dated 10/6/2023, revealed "Patient sent to "proper name of hospital" with meds for psych evaluation ..."<br><br>Record review of a "Psychiatric Evaluation" dated 10/6/23, on Resident #3, revealed "Nursing home staff complained of resident having increased agitation. Argumentative with staff and roommate, possibly paranoid about roommate ...with a psychiatric history of schizoaffective disorder bipolar type, major depressive disorder, anxiety and panic disorder ..."<br><br>Record review of a "Discharge Summary" from the local hospital dated 10/12/23, for Resident #3 revealed "Patient was admitted ...with a new medication started, adjusted, and titrated to efficacy ....Buspar was increased to 10 mg (milligrams) bid (twice a day) ...He was started on Seroquel on day of admission from the nursing home ..."<br><br>Record review of "Discharge Medications" for Resident #3 revealed " New Medications to start taking, Buspar (Buspirone)-Take 10 milligrams | F 644 | status in Daily Clinical Start UP beginning 12/08/2023.<br>Registered Nurse Assessment Coordinator will run list weekly to identify any new mental health diagnosis that would warrant a significant change form to be submitted to State Designated Authority. This will be reviewed in Clinical Start up beginning 12/08/2023.<br><br>4. Director of Nursing, Social Services Director, And Director of Clinical Coordinator will monitor all residents beginning 12/8/2023 for Preadmission Screening and Resident Review Level 2 review as indicated for admission, newly evident or possible serious mental disorder, intellectual disability, or significant change in status assessment each week for four weeks, then monthly for two months to identify any discrepancies. Any variance will be corrected immediately and addressed in Quality Assurance and Performance Improvement. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |

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| F 644 | Continued From page 15<br>(mg) by mouth twice daily."<br><br>During an interview with the Licensed Social Worker (LSW) on 12/6/23 at 8:57 AM, she stated she did not submit a change in status referral for a Level II resident review following Resident #3's psychiatric stay. She stated the purpose for submitting a change in status referral for a Level II resident review is to ensure that the resident is properly placed and make sure that the resident is getting the level of care needed. She stated that the change in status resident review may provide additional interventions that the resident may need and by not submitting one may prevent the resident from receiving the care he needed.<br><br>During an interview with the Administrator on 12/6/23 at 9:04 AM, she verified it was her expectation that a change in status referral for a Level II resident review would have been submitted for Resident #3 following his psychiatric stay.<br><br>A record review of the Admission Record for Resident #3 revealed that he was admitted to the facility on 4/23/2022 with diagnoses that include Schizoaffective Disorder and Bipolar Disorder. | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 | F 656 | | 1/4/24 |

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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 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 observation, record review, resident

1. An Immediate review was completed

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| F 656 | Continued From page 17<br>interview, staff interview and facility policy review the facility failed to develop and implement a care plan for a resident who was self- administering medications (Resident #28) failed to implement a care plan for activities of daily living (ADL) care for (Resident #48 and #44) and failed to implement a care plan for fluid restriction (Resident #12) for four (4) of 28 care plans reviewed.<br><br>Findings include:<br><br>Review of the facility policy titled, "Care Plans," dated October 2021, revealed Policy: "Care plans will be developed and implemented for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines.<br><br>Resident #12<br><br>Review of the care plan for Resident #12 titled, "At risk for Alteration in Kidney Function due to DX (diagnosis) of End Stage Renal Disease (ESRD) requiring hemodialysis treatments." ... Interventions: ... Fluid restriction as directed: "1 L (liter) fluid restriction Nursing to provide: 200 cc (cubic centimeter) on 7a-7p (AM/PM) shift, Nursing to provide 200 7p-7a (PM/AM) shift Dietary to provide: 12 oz (ounces) fluids on breakfast tray 4 oz fluids on lunch tray 4 oz fluids on dinner tray." ...<br><br>During an observation on 12/04/23 at 11:30 AM, Resident #12 was drinking from a water pitcher and then placed the pitcher on her bedside table.<br><br>Review of the December 2023 Medication Record for Resident #12, revealed "Fluid restriction as | F 656 | by the interdisciplinary team on 12/5/2023 for resident #44, Resident #48, Resident #12 and Resident #28 with care plans update appropriately. Kardex for Residents #48, #44, Resident #12, and Resident #28 were reviewed by Interdisciplinary Team on 12/8/2023 to ensure communication of each resident's plan of care to Certified Nursing Aids.<br><br>2. All Residents have the potential to be affected by this alleged deficient practice.<br><br>3. 100% audit of each resident's Kardex was completed on 12/8/2023 by the Interdisciplinary team on 12/8/2023 for all residents. No other resident were identified as being impacted. 100% of nursing staff were in serviced on 12/7/2023 on following the care plans and the importance of not only following residents care plan but also identifying and reporting any discrepancies in the resident's care plan. Nurses and Certified Nursing Assistant were also educated on the importance of providing activities of daily living with focus of oral care and shaving by Director of Nursing and Director of Clinical Education. Nursing staff were educated n 12/7/2023 policy for resident's that desire to perform medication self administration by Director of Nursing.<br><br>4. Director of nursing Services, Assistant Director of Nursing, and other team members will audit care plans of 4 residents four times weekly for four weeks, then twice weekly for two weeks, | |

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| F 656 | Continued From page 18<br>directed: 1 L (liter) fluid restriction Nursing to provide: 200 cc fluids on 7a-7p shift ... Nursing to provide: 200 7p-7a (shift ... Dietary to provide: 12 oz fluids on breakfast tray ... 4 oz fluids on lunch tray ... 4 oz fluids on dinner tray" ... two times a day triggering at 6:00 AM and 6:00 PM" with 120 cc document for both shifts with no documentation of Resident #12's 24 hour total fluid intake.<br><br>Review of the Visual/Bedside Kardex Report for Resident #12 revealed, "Encourage fluids within her restriction." ...<br><br>An interview with the Director of Nursing (DON) on 12/05/23 at 2:46 PM revealed after review of the CNA (Certified Nurse Assistant) Care guide for Resident #12 the CNAs would not know the amount of fluid restriction Resident #12 is on because the Care guide does not specify the amount of fluid restriction. The DON also confirmed after review of the ESRD care plan for Resident #12 staff were not following the care plan for following fluid restriction as directed and the purpose of the care plan is to ensure the staff provide the resident specific care they need.<br><br>Record review of the Admission Record revealed that the facility admitted Resident #12 to the facility on 12/04/23 with diagnosis of Rend Stage Renal Disease and Fluid Overload, unspecified.<br><br>Resident #28<br>An observation of Resident #28's room and interview on 12/4/23 at 11:07 AM, revealed two (2) plastic vials laying on the overbed table. Resident #28 revealed that the 2 vials were her breathing treatment medications, and she prefers to give herself the breathing treatment at a later | F 656 | then monthly for two months to include checking the resident's care plan, Kardex to validated they match each other and contain all pertinent information needed to provide and meet needs and wishes of residents beginning 12/08/2023. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement committee monthly for further review. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |

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time, so the nurses leave them for her.

On 12/4/23 at 11:11 AM, during an observation and interview with Licensed Practical Nurse (LPN) #3 she verified that Resident #28 did not like to take her breathing treatments when they were due so they left them in the room so that she could give them to herself when she was ready.

A record review of Resident #28's care plan revealed that there was no care plan indicating that the resident self-administered her own breathing treatments.

An interview on 12/5/23 at 3:25 PM, with the DON she verified that Resident #28's care plan did not indicate that the resident self -administered her own breathing treatments. She agreed that there was no way for the nursing staff to know that the resident preferred to or was safe to administer her own breathing treatment and that it should have been reflected on the resident's care plan.

A record review of the Admission Record for Resident #28 revealed that the resident was admitted on 3/7/2017 with diagnoses that include Chronic Obstructive Pulmonary Disease and Malignant Neoplasm of Right Main Bronchus.

A record review of Resident #28's MDS with an ARD of 10/13/23 revealed a BIMS score of 15, indicating that the resident is cognitively intact.

Record review of Resident #44's Care Plan revealed under Focus: "Self-Care Deficit related to: decreased functional abilities, impaired cognition/dementia, weakness, Alzheimer's, Dementia" with the following Interventions to

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include: "Nail, hair, and oral care daily and as needed, Provide all the effort with the following task as this resident is dependent: oral hygiene, toilet hygiene, shower/bathe self, lower body dressing, put on/take off footwear, personal hygiene..... Provide cueing, supervision, and assistance with ADLs as needed."

An observation on 12/05/23 at 8:40 AM, revealed Resident #44 sitting up in her wheelchair in her room. Resident's front lower teeth observed with yellow and white substance on the lower teeth and gum line. When resident was asked about her mouth care and if her teeth had been brushed, she said, "No one brushed my teeth."

On 12/05/23 at 4:05 PM, an interview with Licensed Practical Nurse (LPN) #3 in Resident #44's room, confirmed the yellow and white substance on Resident #44's bottom front teeth and LPN #3 revealed that it didn't look like resident's teeth had been brushed.

Record review of Resident #44's Comprehensive Admission Minimum Data Set (MDS) with Assessment Reference Date of 09/05/2023 under Section GG was documented under GG0130 Self Care B. that Resident #44 was dependent with the ability to use suitable items to clean teeth. Section C was documented that she had a Brief Interview for Mental Status (BIMS) score of 03 which indicated that resident had severe cognitive deficits.

Record review of Resident #44's Admission Record documented Admission Date of 08/29/2023 and had the following diagnoses to include: Need for Assistance with Personal Care. Resident #48

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| | 255139 | A. BUILDING _____ B. WING _____ | 12/07/2023 |

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| DIVERSICARE OF BATESVILLE | 154 WOODLAND ROAD BATESVILLE, MS 38606 |

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| F 656 | Continued From page 21<br>Record review of the care plan for Resident #48 with a date initiated of 10/13/23 revealed "Focus I have an Activities of Daily Living (ADL) self-care performance deficit...Interventions ...Provide substantial/moderate assistance ... with personal hygiene ..."<br><br>An observation and interview on 12/04/23 at 12:42 PM revealed Resident #48 had facial hair approximately two (2) inches long on his face and his daughter stated a Certified Nurse Assistant (CNA) was in earlier trimming his beard with scissors.<br><br>An interview, on 12/06/23 9:51 AM, with the Director of Nursing (DON) confirmed Resident #48 should have been shaved.<br><br>On 12/07/23 at 10:55 AM, an interview with the Registered Nurse (RN) MDS coordinator revealed the purpose of the care plan is to let staff know how to care for the residents. If a care plan is written and the staff does not do what it says, the care plan was not followed.<br><br>Review of the facility Admission Record revealed Resident #48 was admitted to the facility on 10/13/23 with diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side and Aphasia following Cerebral Infarction.<br><br>Review of Section C of the Admission MDS with an ARD of 10/20/23 revealed a BIMS was not conducted due to Resident #48 was rarely/never understood. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2) | F 677 | | 1/4/24 |

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| F 677 | Continued From page 22<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident , family, and staff interviews, record review, and facility policy review, the facility failed to provide oral care for a resident (Resident # 44) and failed to shave a resident (Resident #48) for two (2) of 28 residents reviewed for activities of daily living (ADL's).<br><br>Findings include:<br><br>Record review of "Clinical Nursing Skills and Techniques, Perry & Potter, page 457 documented under "Oral Care" the following: "Maintenance of daily oral hygiene, including brushing, flossing, and rinsing, is essential for the prevention and control of plaque-associated oral diseases..."<br><br>The facility did not provide a policy directly related to shaving a resident.<br><br>Resident #44<br><br>An observation on 12/04/23 at 2:10 PM, revealed Resident #44's front lower teeth with yellow and white substance attached to gum line and between teeth. It did not appear that mouth care was being completed on this resident.<br><br>An observation on 12/05/23 at 8:40 AM, revealed Resident #44's lower teeth appeared dirty with yellow and white substance observed on the | F 677 | 1. Certified Nursing Assistant completed oral care for resident #44 on 12/06/2023. Resident #48 had facial hair removed by Certified Nursing Assistant on 12/6/2023.<br><br>2. All residents requiring assistance with activities of daily living are at risk for the deficient practice.<br><br>3.100% audit all residents to identify any in need or oral care or facial hair removal was conducted on 12/06/2023 by the Director of Nursing and Assistant Director of Nursing. Care was provided immediately if need identified. 100% in service conducted with licensed nursing staff and Certified Nursing aids on 12/6/2023 by Director of Clinical Education for providing ADL care to residents with focus of oral care and facial hair. Interdisciplinary team will review completion of assigned documentation to include ADL care provided daily during Clinical Start Up starting 12/08/2023<br><br>4. Interdisciplinary Team will audit four residents four times a week for two weeks, then weekly for two months to assure activities of daily living with increased focus of oral hygiene and facial hair removal is performed starting 12/8/2023. All variances will be | |

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| F 677 | Continued From page 23 | F 677 | | |

lower teeth and gum line and when asked about mouth care, the resident said no one had brushed her teeth.

On 12/05/23 at 4:00 PM, an observation and interview with Lead Certified Nursing Assistant (CNA), revealed that oral care was supposed to be done on all residents every day. She revealed that this was basic care and just common sense to do this every day. Lead CNA observed Resident #44's teeth and stated, "Naw they (Resident's teeth) haven't been brushed."

On 12/05/23 at 4:05 PM, an interview with Licensed Practical Nurse (LPN) #3 confirmed the yellow substance on Resident #44's teeth and revealed that it didn't look like the resident's teeth had been brushed.

On 12/05/23 at 4:15 PM, an interview with LPN #2 revealed that failure to brush and clean resident's teeth could cause a lot of things and lead to tooth decay and infection.

On 12/06/23 at 8:15 AM, an interview with Assistant Director of Nursing (ADON) revealed that they did not have a policy on Activities of Daily Living which included oral care. She revealed that the facility adopted "Clinical Nursing Skills and Techniques, Perry & Potter," as a supplementary policy and procedure guide effective January of 2023.

Record review of Resident #44's Comprehensive Admission Minimum Data Set (MDS) with Assessment Reference Date of 09/05/2023 under Section GG was documented under GG0130 Self Care B. that Resident #44 was dependent with the ability to use suitable items to clean teeth.

immediately corrected and addressed in Quality Assurance and Performance Improvement. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months.

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| F 677 | Continued From page 24 | F 677 | | |

Section C revealed that she had a Brief Interview for Mental Status (BIMS) score of 03 which indicated that resident had severe cognitive deficits.

Record review of Resident #44's Admission Record documented admission date of 08/29/2023 and the following diagnoses to include: Alzheimer's Disease, Weakness, and Need for Assistance with Personal Care.

Resident #48

An observation during the initial tour on 12/04/23 at 12:42 PM, revealed Resident #48 had facial hair approximately 2 inches long on his face. An interview with Resident #48's daughter at the same time revealed a CNA was in earlier trimming her father's beard with scissors. She stated that her father likes to be clean shaven and have his hair cut close to his head.

An observation of Resident #48 and interview on 12/5/23 at 10:30 AM, with CNA #3 revealed that she shaved the resident this morning. She stated that she had to cut his beard down and then shave him. She stated she let Resident #48 see himself when she finished, and he was so happy and smiling.

An interview, on 12/06/23 at 09:51 AM, with the Director of Nursing (DON) revealed that Resident #48 will put his hand up to his face when staff are attempting to help him, but it is like a natural reflex. She stated they are working with the staff on residents' individual preferences and the need to make more than one attempt at care. She confirmed Resident #48 should have been shaved.

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| F 677 | Continued From page 25<br><br>Review of Section GG- Admission with an effective date of 10/16/23 revealed in section I1. Personal Hygiene: 02. Substantial/maximal assistance.<br><br>Review of the facility Admission Record revealed Resident #48 was admitted to the facility on 10/13/23 with diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side and Aphasia following Cerebral Infarction.<br><br>Review of Section C of the Admission MDS with an ARD of 10/20/23 revealed a BIMS was not conducted due to Resident #48 was rarely/never understood. | F 677 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, record review, and facility policy review, the facility failed to put safety measures in place to prevent an accident during van transport for one (1) of five (5) residents reviewed. Resident #66<br><br>Findings include: | F 689 | 1. 911 called immediately 10/09/2023 by the van driver and the resident was transported to the hospital by Emergency Medical Services. Interview with reenactment by the van driver witnessed by the administrator and social Services Director completed on 10/09/2023. Van Driver was scheduled a drug screen on | 12/21/23 |

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| F 689 | Continued From page 26<br>Record review of the facility policy titled, "Inspections, Repairs, and Maintenance", with an effective date of September 1, 2019, revealed, "Statement: It is the policy of (Proper Name of Facility) to keep all vehicles well maintained and in safe, efficient operating condition at all times ... Rules of vehicle operation ...7. All passengers must be seated in vehicle seats with occupant restraint ..."<br><br>Record review of the facility policy titled "Vehicle Safety Guidelines" with a revision date of January 1, 2023, revealed "The safety of our patients/residents, passengers, team members, the public and the protection of the property of others is important to the company ..."<br><br>An interview on 12/04/23 at 1:15 PM, with Resident #66 revealed that she was in an accident in the facility van a few months ago and suffered a fractured leg. She stated that her wheelchair was secured in the van, but the shoulder strap/seatbelt was not working, so she did not have it on and when the driver made a sudden stop, she fell out of the wheelchair.<br><br>Record review of the Incident Report Form revealed, "Date of incident: 10/09/2023, Approximate time of incident: 4.00 PM Location of incident: ...Hwy 7 of Greenwood, MS while being transported per facility van from a scheduled appointment ...Resident fell face forward to the floor out of the wheelchair in the facility van when driver made a fast stop ... (Proper Name of Resident #66) experienced a fall while seated in her wheelchair on the facility van. Resident was transported by EMS (emergency medical services) to local ER (emergency room). X rays were obtained. (Proper Name of Resident | F 689 | 10/09/2023 at Clinic. Van Driver placed on administrative leave pending outcome of investigation on 10/09/2023 by Administrator. Personnel file of van driver reviewed by administrator on 10/10/2023, to assure abuse and neglect and van training was completed prior to incident. Regional Vice President, Director of Clinical Operations, and Senior Director of Clinical Operations notified on 10/09/2023 by the Administrator. Root Cause and Analysis of incident performed during reenactment. Van to be taken out of service on 10/09/2023 until sanitizing and assessed for proper fit and function of the restraints. Incident reported to State Agency on 12/21/2023.<br><br>2. Any resident being transferred by the van can be potentially affected.<br><br>3. The Administrator completed 100% of transfers for the past 3 months to assure no other prior incidents on 10/10/2023. 100% Education regarding safe van transfers completed on 10/10/2023 to be provided to alternate van drivers prior to any other resident transfer. Abuse and Neglect training to be initiated to all staff on 10/09/2023. Safety checks to be conducted by van driver before each transfer to assure proper function and application of restraints starting on 10/10/2023. Van to inspected on a weekly basis by the maintenance director to assure proper function starting on 10/10/2023.<br><br>4.Administrator or Maintenance Director | |

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| F 689 | Continued From page 27<br>#66) has a broken leg ..."<br><br>Record review of the History and Physical from the emergency room (ER) visit dated 10/9/23 revealed, "Admitting Diagnosis: Femur fracture ...MVA (motor vehicle accident) ...in a nursing home van in a wheelchair we had a sudden break was applied and she was thrown out of her wheelchair and sustained deep laceration to left shin, EMS (emergency medical services) was called and they reported large amount of blood on scene and she was hypotensive. In the ER she was given IV (intravenous) fluids with improvement in blood pressure ...Of note patient is on Eliquis (blood thinner) ...x-ray left femur showed comminuted impacted distal femoral metaphyseal fracture ..."<br><br>An interview on 12/5/23 at 10:30 AM, with the Administrator (ADM) confirmed that she did not report the incident to the State Agency (SA) because the resident was not on the premises when it occurred. She looked at it as a motor vehicle accident. She confirmed the facility van driver should have fastened the residents' seat belt and, if the seat belt was not working, he should have moved her into the other space in the van. The ADM confirmed the van driver no longer works here.<br><br>An interview with Maintenance Staff #1 on 12/07/23 at 9:21 AM, revealed he found out about the incident the next day. He stated they have a check off form the driver should do daily and document. Maintenance Staff #1 confirmed the check off was not done on 11/9/23. He stated he looked at the seat belt the next day and it was not functioning properly. He stated the Seat belt/Shoulder strap would not pull out because | F 689 | will begin monitoring on 10/12/2023 for proper safety technique compliance with 5 transfers weekly for 4 weeks followed by two transfers weekly for four weeks, including proper securing residents in the van prior to leaving the center to assure the van driver's compliance with safety measures. Any variance will be addressed immediately. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 10/24/2023 monthly times three months. | |

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| F 689 | Continued From page 28 | F 689 | | |

the ratchet was not releasing.

A record review and interview with the ADM on 12/7/23 at 9:25 AM, confirmed the check off form was not done by the van driver on the day of the incident, 11/9/23.

Record review of the November 2023 van calendar revealed no documentation was made on 11/9/23.

Record review of the Q'STRAINT user instructions revealed, " ...B Secure Passenger 1. Attach Lap Belts ...2. Attach Shoulder Belt ...."

Review of the "Statement from Van Incident" revealed the ADM interviewed the van driver on October 9, 2023. The van driver revealed he had to make a fast stop due to a vehicle in front of him turned quickly. The fast stop caused a fall to the resident. (Resident #66). The van driver revealed that he did not have the resident secured because the seatbelt didn't pull out far enough. He revealed that he did not use the other seatbelt on the bus because he was in a hurry to get the resident to her appointment.

Review of the Admission Record revealed Resident #66 was admitted to the facility on 11/10/22 with diagnoses that included unspecified Osteoarthritis, Muscle Weakness, Abnormal Posture, and nondisplaced comminuted fracture of shaft of Left Femur.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #66 was cognitively intact.

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| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review and facility policy review the facility failed to ensure a resident on fluid restriction was monitored for one (1) of 13 residents on fluid restriction. Resident #12.<br><br>Findings include:<br><br>Review of the facility policy titled, "Fluid Restriction," revised 9/2017, revealed Policy Statement: "A fluid restriction will be implemented only as part of a therapeutic diet prescription ...Procedures: 4. The Nursing Services will be responsible for tracking and documenting the | F 692 | 1. Water Pitcher was immediately removed for the room of Resident #12 on 12/5/2023.Resident #12 was assessed on 12/5/2023 by Director Of Nursing. There were no negative finding for this resident.<br><br>2. All residents in the center with fluid restrictions orders are at risk for the deficient practice.<br><br>3.100% Audit of residents rooms on fluid restrictions for water pitchers completed on 12/5/2023 by the Director of Nursing Services to identify any opportunities in | 1/4/24 |

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| F 692 | Continued From page 30<br>total volume consumed in accordance with the facility policy..."<br><br>An observation on 12/04/23 at 11:30 AM, revealed Resident #12 drinking from a water pitcher and then placed the pitcher on her bedside table.<br><br>An interview on 12/05/23 at 2:00 PM, with Certified Nurse Assistant (CNA) #1 and CNA #2, both revealed that Resident #12 was not on any type of fluid restriction.<br><br>An observation and interview with Licensed Practical Nurse (LPN) #1 on 12/05/23 at 2:10 PM, confirmed Resident #12 had a water pitcher with ice and water sitting on her bedside table and confirmed Resident #12 should not have the water pitcher in her room. After review of Resident # 12's physician's orders LPN # 1 confirmed Resident #12 was on a 1 Liter fluid restriction because she is on dialysis and has End-stage Renal Disease. LPN #1 revealed a possible concern from having the extra fluids in the room is fluid overload. She was unaware if Resident #12 was on Intake and Output (I & O), and she did not know where to look for the documentation.<br><br>An interview with the Director of Nursing on 12/05/23 at 2:46 PM, she confirmed after review of the physician's orders for Resident # 12 that she was on a 1 (one) Liter fluid restriction and should not have a water pitcher in her room. The DON then revealed after review of the Medication Record for Resident #12 that staff were only documenting the 120 milliliters provided during medication administration for both shifts and were not monitoring the 24-hour total intake for | F 692 | fluid restriction monitoring. 100% review of all care plans and Kardexs for resident's on fluid restrictions was completed on 12/5/2023. Care plans and Kardexs were updated by Director of Nursing, Assistant Director of Nursing, and Unit Managers to reflect fluid restrictions as indicated. Interviews will be conducted starting 12/5/2023 by Director of Nursing or team member with identified residents who are compliant versus residents who are non-compliant of risk. Review and update care plan as needed to reflect compliance. Interdisciplinary Team to monitor residents and update care plan changes in compliance as well as assuring Kardex reflects fluid restrictions. Education was provided by Director of Clinical of Education on 12/5/2023 to Certified Nursing Aides and Licensed nurses on protocol for fluid restriction.<br><br>4.Interdisciplinary Team will review all new orders for fluid restrictions for appropriate documentation and implementation during Daily Clinical Start up meeting beginning 12/05/2023. Director of Nursing Services or team member will audit on all residents on fluid restrictions three times weekly for four weeks then once weekly for two months. Any variance to procedure will be corrected immediately and addressed by Director of Nursing. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |

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| F 692 | Continued From page 31 | F 692 | | |

Resident #12 and confirmed that the staff should have been doing so. She then revealed that with the water pitcher in Resident #12's room staff would not know the true amount of fluids taken in by Resident # 12.

Review of the electronic medical record revealed a physician's order for Resident #12, dated 2/13/23 "Fluid restriction as directed: 1 (one) L (liter) fluid restriction Nursing to provide: 200 cc (cubic centimeters) fluids on 7a-7p (AM/PM) shift ... Nursing to provide: 200 cc on 7p-7a (PM/AM) shift ... Dietary to provide: 12 oz (ounces) fluids on breakfast tray ... 4 oz fluids on lunch tray ... 4 oz fluids on dinner tray ... two (2) times a day related to Dependence on Renal Dialysis; End Stage Renal Disease."

Review of the December 2023 Medication Record for Resident #12, revealed "Fluid restriction as directed: 1 L (liter) fluid restriction Nursing to provide: 200 cc fluids on 7a-7p shift ... Nursing to provide: 200 7p-7a (shift ... Dietary to provide: 12 oz fluids on breakfast tray ... 4 oz fluids on lunch tray ... 4 oz fluids on dinner tray" ... two times a day triggering at 6:00 AM and 6:00 PM" with 120 cc document for both shifts with no documentation of Resident #12's 24 hour total fluid intake.

Record review of the Admission Record revealed that the facility admitted Resident #12 to the facility on 12/04/23 with diagnosis of Rend Stage Renal Disease and Fluid Overload, unspecified.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/10/23, revealed that Resident #12 had a Brief Interview of Mental Status (BIMS)

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| | 255139 | A. BUILDING _____ B. WING _____ | 12/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIVERSICARE OF BATESVILLE | 154 WOODLAND ROAD BATESVILLE, MS 38606 |

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| F 692 | Continued From page 32<br>score of 7 which indicated that she was cognitively severely impaired. Section I revealed End stage renal disease and Fluid Overload, and unspecified coded as active diagnoses. | F 692 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and | F 758 | | 1/4/24 |

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| F 758 | Continued From page 33<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to a provide a stop date on a psychotropic as needed (PRN) medication for one (1) of four (4) residents reviewed for unnecessary psychotropic medication use. Resident 68.<br><br>Findings Include:<br><br>A record review of a document titled, "Med Tip, Improving Quality Outcomes", provided by the facility, revealed "New Guidance Around PRN Psychotropic Medications...prn psychotropic medications are ordered for no more than 14 days..."<br><br>A record review of Resident # 68's Hospice Physician's Order revealed an order for Lorazepam Oral Concentrate 2 (two) milligrams per milliliter (mg/ml) Give 0.25 ML by mouth every six (6) hours as needed for agitation and restlessness with an onset date of 11/20/23 and | F 758 | 1. Attending Medical Provider was contacted on 12/07/2023 with order obtained to discontinue anxiolytic medication for Resident #48. Order was immediately executed with medication discontinued. Resident #48 was assessed on 12/7/2023 by Director of Nursing. There were no negative findings for this resident.<br><br>2. All residents receiving PRN (as needed) psychotropic medications is at risk for the deficient practice.<br><br>3.100% audit was conducted by the interdisciplinary team on 12/7/2023 of all residents receiving PRN (as needed) psychotropic medications to ensure have discontinuation date no longer than 14 days. Any variances were corrected immediately. 100% education by Director of Nursing on 12/7/2023 with licensed | |

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| F 758 | Continued From page 34<br>no stop date.<br><br>A record review of the facility's orders for Resident #68 revealed an order for Lorazepam Oral Concentrate 2 mg/ml Give 0.25 ML by mouth every 6 hours as needed for agitation and restlessness with an onset date of 11/20/23 and no stop date.<br><br>During an interview with the Director of Nursing (DON) on 12/6/23 at 2:10 PM, she stated that she was aware that as needed antianxiety medications are to have a 14 day stop date. She confirmed that Resident #68 has an order for Lorazepam Oral Concentrate 2 MG/ML every 6 hours as needed ordered on 11/20/23 that did not have a stop date. The DON stated that they check orders in their morning meeting to ensure that any antianxiety medication has a stop day and agreed that this medication was missed.<br><br>During an interview with the DON on 12/7/23 at 8:25 AM, she stated that the purpose for having a stop date on an as needed anxiety medication was because the medication is likely ordered due to an acute situation and the resident would not need to receive the medication for a long period of time.<br><br>During an interview with the DON on 12/7/23 at 10:47 AM, she verified it is the facility's practice to follow the "Med Tip Guidance around PRN Psychotropic Medications" from the 2016 State Operations Manual regarding the use of psychotropic medications.<br><br>Review of the Admission Record for Resident #68 revealed the resident was admitted on 11/10/23 with a diagnosis of Dementia. | F 758 | nursing staff for obtaining an order for discontinuation on all PRN (as needed) psychotropics and use to not exceed fourteen days without further medical provider assessment in the facility for continuation of medication for each reinstatement of order. Interdisciplinary Team will review all new psychotropic medication orders during daily Clinal start up meeting beginning on 12/08/2023 for appropriate discontinuation date. And discrepancies will be immediately addressed and corrected. Director of Nursing will provide education on 12/8/2023 with medical providers for ensuring regulation of PRN (as needed) psychotropic medication use in implemented. Education will be provide by Director of Clinical Education or team member for all newly hire licensed nursing staff on regulation of PRN (as needed) psychotropic medication us e with additional training as needed to ensure all PRN (as needed) psychotropic medications are discontinued within fourteen days.<br><br>4. Interdisciplinary Team to review during Clinical Start Up of any changes to ensure all PRN (as needed) psychotropic medication has a stop date per compliance with regulations beginning 12/8/2023. Continuing education on auditing prn (as needed) anxiety orders. Director of Nursing Services or team member will audit all PRN (as needed) psychotropic medications three times a week for one month, once a week for one month, then once monthly for one month | |

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| F 758 | Continued From page 35 | F 758 | beginning on 12/11/2023. Any variance to procedure will be Corrected immediately and addressed by Director of Nursing Services. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months. | |