MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41TM	A. BUILDING: _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #24046 at the facility from 02/07/24 through 02/08/24. The SA investigated CI MS #24046 for residents not turned/repositioned timely, residents not treated with dignity and respect, inappropriate feeding assistance, residents not assessed after change in condition, pressure sores, residents not groomed adequately. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident, family, and staff interviews, record review, and facility policy review the facility failed to ensure that a resident received her scheduled baths in January and failed to provide nail care for one (1) of nine (9) residents reviewed for Activities of Daily Living (ADLs). Resident #1	M 610	1. On 02/07/2024, Resident #1 nails were clipped and both hands cleaned. On 2/7/2024, the Administrator and Director of Nursing conducted an audit of resident nails. Negative findings were addressed at that time.	3/11/24

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M 610	Continued From page 1 Findings Include: Record review of the facility policy titled, "ADL's" (Activities of Daily Living), with effective date August 2021, revealed Policy: "Ensure ADLs (Activities of Daily Living) are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences..." On 02/07/24 at 10:30 AM, an observation and interview with Resident #1, revealed her lying in bed in her room. Resident #1's right hand was closed tightly and resting on the bed down by her side. Resident #1 revealed that she normally got a bath every other day but had missed a few baths over the last few weeks and revealed that they washed her hair about once a week. On 02/08/24 at 12:50 PM, a phone interview with Resident #1's Resident Representative (RR), revealed that the care at the facility was pretty good but that they sometimes left soap in Resident #1's hair and left her fingernails too long. He revealed that her fingernails needed cutting real bad now and that she holds her right hand closed tightly and stated, "Her fingernails dig into her hand. Can you get her nails taken care of for me? They need to open her hand up and wash it, it stinks. We shouldn't have to bring it to their attention, they should know how to take care of these people here." On 02/07/24 at 1:30 PM, an observation and interview with Resident #1 revealed her lying in bed in her room with her right hand clasped shut in a tight fist with her fingernails pressed firmly against the palm of her hand. There were three indention's to the palm of her hand the shape and	M 610	On 2/8/2024, Therapy services screened Resident #1 for splint to right hand to aid with contracture management. 2. All residents have the potential to be affected by this practice. 3. Beginning the week of 2/12/2024, the Administrator, Director of Nursing and Director of Clinical Education began in-servicing with staff regarding the facility policy for Activities of Daily Living (ADL) and the policy regarding documentation of care delivery. 4. Beginning the week of 2/12/2024, the Director of Nursing, Administrator and Registered Nurse(s) began observation rounds to assure Activities of Daily Living (ADL) care completed as care planned. Observation rounds to occur three times a week for four weeks, then weekly for four weeks. Beginning the week of 2/12/2024, the Director of Nursing, Administrator, and Health Information Management Nurse to conduct a review of Activities of Daily Living (ADL) documentation five times a week for four weeks, then three times for four weeks. Any negative findings will be addressed at that time. Findings of observation rounds and documentation review monitoring will be brought to the Quality Assurance Performance	

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M 610	Continued From page 2 size of the end of fingernail of her index, middle, and fifth fingers. There was redness observed in the palm of her hand near the base of her thumb where her index fingernail was pressing into the skin. It was noted a foul odor when her hand was opened and resident stated, "I want them cut." She revealed that she didn't like long fingernails and wanted someone to cut them. Her fingernails were observed to be about ½ inch long. Resident #1 also revealed that she had missed a few baths since she had been here. On 02/07/24 at 3:10 PM, an interview with Licensed Practical Nurse (LPN) #1, confirmed that Resident # 1's fingernails were long and were pressed tightly into her palm causing the indention's in the shape of her nails in three places. She revealed that the CNAs were supposed to check the residents' nails when they gave their baths. She revealed that Resident #1 scheduled bath days were Tuesdays, Thursdays, and Saturdays so she would have gotten a bath yesterday and stated, "No, they didn't cut her nails, and they should have." LPN #1 also confirmed the foul odor when Resident #1's right hand was opened. She revealed that as long as Resident #1's nails were cut short, they didn't cause indention's to her hands. She revealed that the resident's longer fingernails could have caused a wound to her hand and confirmed that they would get her right hand washed and her fingernails clipped right away. On 02/07/24 at 3:20 PM, an interview with Administrator revealed that leaving Resident #1's fingernails too long could have caused a wound to her hand and that her nails should have been clipped and she confirmed that the resident missed four of her scheduled baths in the month of January and when they failed to keep her	M 610	Improvement committee for review and recommendations on 02/23/2024, then monthly for three months.	

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M 610	Continued From page 3	M 610		

fingernails clipped.

On 02/08/24 at 11:35 AM, an interview with Director of Nursing (DON), revealed that if a resident's fingernails were not clipped and if a resident missed her baths, then the resident was not receiving her care she needed, especially because she was dependent on the staff.

On 02/08/24 at 11:50 AM, an interview with Certified Nursing Assistant (CNA)#1 revealed that the CNAs were responsible for giving the residents assigned to them their baths or showers. She stated, "Sometimes we don't get around to getting everything done that needs to be done. We do the best we can. Sometimes the baths or showers does get missed."

On 02/08/24 at 12:05 PM, observed Resident #1's RR feeding her lunch. He revealed that he had walked in before and found soap in Resident #1's hair where they hadn't rinsed it out good and he had walked in other times when her hair looked a mess and was dirty looking like it hadn't been washed in a long time. He revealed that they needed to do better than this.

On 02/08/24 at 1:20 PM, during an interview with the Administrator and record review of Resident #1's "Documentation Survey Report" she confirmed that her baths were not documented for four days in January 2024. She revealed that documentation was missing on 01/16/24, 01/18/24, 01/23/24, and 01/30/24 which indicated that Resident #1's baths were missed. The Administrator agreed that since Resident #1's nails were not clipped and since she had missed four baths in the month of January, they had missed days to take care of the resident's nails.

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M 610	Continued From page 4 Record review of "Task: ADL - Bathing" Schedule for Resident #1 revealed that her scheduled bath days every week were Tuesday, Thursday, and Saturday on the 7AM - 3PM shift. Record review of Resident #1's "Documentation Survey Report" for the month of January 2024, revealed there was no documentation that Resident #1 received her scheduled baths on 01/16/24, 01/18/24, 01/23/24, and 01/30/24. Record review of Resident #1's "Admission Record" revealed an admission date of 05/12/2021 with diagnoses that included Dysphagia, Pain, Reduced Mobility, Contracture of right hand, and need for assistance with personal care. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/04/2024 under Section C was documented a Brief Interview for Mental Status (BIMS) Score of 10 which indicated she had moderate cognitive deficits.	M 610		