STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	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

(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
F 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. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. 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 and cited F656 and F677. At the time of the survey the facility held a census of 105 and was licensed for 120 beds.	F 000		
F 656 SS=D	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		3/11/24

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

Electronically Signed | 02/24/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 observation, interviews, record reviews and facility policy review the facility failed to ensure that a comprehensive care plan was implemented for one (1) of nine (9) residents reviewed for Activities of Daily Living (ADLs). Resident #1 Findings Include: Record review of the facility policy, "MDS (Minimum Data Set) and Care Plans with effective date of August, 2019 revealed,"Policy:	F 656	1. On 2/7/2024, Resident #1 nails were clipped and hands cleaned by the Administrator. 2. All residents have the potential to be affected by the practice. Beginning 2/9/2024, the Minimum Data Set (MDS), Health Information Management Nurse, Director of Nursing and Administrator conducted an audit of resident care plans to assure	

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F 656	Continued From page 2 Care plans and MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines." Record review of Resident #1's Care Plan initiated on 05/11/2023 revealed " Focus: Self-Care Deficit related to: decreased functional abilities, impaired cognition/dementia, pain, weakness...Interventions ... Assist with bathing as needed ... Nail, hair, and oral care daily and as needed. Observe skin for alterations in skin integrity during baths and ADL (Activities of Daily Living) care - report to nurse as needed ..." During a phone interview on 02/08/24 at 12:50 PM, 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. Resident's RR revealed that she holds her right hand closed tightly, and "her fingernails dig into her hand," and stated, "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." During an observation and interview on 02/07/24 at 1:30 PM, 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 size of the end of the 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	F 656	Activities of Daily Living (ADL) care plan accuracy for all residents Any negative findings were addressed at that time. 3. On 2/9/2024, the Administrator in-serviced the Minimum Data Set (MDS) nurses regarding the care planning completion process. Beginning the week of 2/12/2024, the Administrator and Director of Nursing began in-servicing staff regarding the facility policy for documentation of Activities of Daily Living (ADL), the schedule for bath/showers and the resident Kardex. 4. Beginning the week of 2/12/2024, the Minimum Data Set (MDS) nurses began an audit of Activities of Daily Living (ADL) careplans in conjunction with the Minimum Data Set (MDS) schedule to assure care plans include appropriate interventions and frequency of care. Beginning the week of 2/12/2024, the Director of Nursing and Administrator will conduct a weekly audit of care plans for ten residents to assure care plans address Activities of Daily Living (ADL) and are being implemented.. Audits to be conducted weekly for four weeks, then monthly for two months.	

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F 656	Continued From page 3 pressing into the skin. It was also noted a foul odor when her hand was opened and Resident #1 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 and also revealed that she had missed a few baths since she had been here. During an interview on 02/08/24 at 11:35 AM, with the Director of Nursing (DON), revealed that the purpose of the care plan was to be able to read and tell everything about the residents and what care they were supposed to receive so that the staff could take care of them. She agreed that if a resident's fingernails were not clipped and if a resident missed her baths, then the care plan was not followed. During an interview and record review on 02/08/24 at 1:20 PM, with the Administrator revealed after reviewing Resident #1's "Documentation Survey Report" 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, her Care Plan had not been followed. Record review of Resident #1's "Admission Record" revealed an admission date of 05/12/2021 and had the following diagnoses: Dysphagia, Pain, Reduced Mobility, Contracture of right hand, and need for assistance with personal care. Record review of Resident #1's Minimum Data	F 656	Findings of the audit will be brought to the Quality Assurance Performance Improvement Committee on 02/23/2024 for review and recommendation monthly for three months.	

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F 656	Continued From page 4 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.	F 656		
F 677 SS=D	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, 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 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	F 677	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. 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	3/11/24

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F 677	Continued From page 5 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 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	F 677	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 Improvement committee for review and recommendations on 02/23/2024, then monthly for three months.	

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F 677	Continued From page 6	F 677		

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 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

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F 677	Continued From page 7	F 677		

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.

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

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F 677	Continued From page 8 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.	F 677		