STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(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 #24010) at the facility on 02/13/24. 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 #24010 for accidents related to an unwitnessed fall and cited F580 for failure to notify the family and physician in a timely manner. At the time of the survey the facility held a census of 110 and was licensed for 152 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		3/20/24

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

Electronically Signed | 03/01/2024

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to notify the physician and resident representative of an unwitnessed fall for one (1) of three (3) residents reviewed. Resident #1. Findings Include: Record review of the facility policy on "Falls" dated February 2017 revealed "Purpose To establish a process that identifies risk and establishes interventions to mitigate the	F 580	1. Resident #1 was assessed upon notification of fall on 1/17/24. Nurse Practitioner (NP) was notified and assessed resident #1 with no negative findings on 1/17/24. On 1/17/24 the Administrator ensured that all residents had contact information input. 2. All residents have the potential to be affected by this deficient practice. Beginning on 1/17/24 Health Information Management Coordinator reviewed 100% of current residents to determine if any	

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F 580	Continued From page 2 occurrence of falls...Post fall...The physician and resident's representative are notified of the fall..." Record review of the Investigation Template dated 1/18/24 revealed that Resident #1 was found on the floor sitting on her buttocks beside her bed on 1/16/24 at approximately 10:50 PM by a Certified Nursing Assistant who was passing by the room and saw her foot beside the bed. The investigation revealed that the resident repeatedly stated that she slid out of bed trying to walk to the bathroom. On 02/13/24 at 8:20 AM, a phone interview with Resident #1's son, revealed that on 01/17/24, his family went to the facility to visit his mom and found that she had a "knot on her head, had two black eyes, and no one from the facility had called to let them know." He revealed that they had the Nurse Practitioner check her out and they did not send her out to the hospital. Resident #1's son stated, "This is unacceptable. I didn't find out until my family went in." Resident #1's son revealed that he lived in Florida, and he depended on them to keep him informed and stated, "They didn't let me know and protocol was not followed." On 02/13/24 at 9:10 AM, an interview with Assistant Director of Nursing (ADON), revealed Resident #1 had a fall on night shift, 11PM- 7AM on 01/16/24. She revealed that as soon as she got to the facility the next morning, she was made aware of Resident #1's fall from the night before. She revealed that there was a small hematoma formed on her forehead and she developed discoloration to both eyes. ADON revealed that the Nurse Practitioner (NP) assessed her the morning of 01/17/24 and there had been no	F 580	other resident were missing contact information. 3. Beginning on 1/17/24 the Director of Clinical Education provided education to licensed nurses regarding established guidelines for notification of changes, specifically notifying the Responsible Party (RP) and Nurse Practitioner/Physician when there is a fall. The Director of Nursing and the Interdisciplinary Team will review the medical record of patients/residents with falls in the morning clinical meeting to validate that RP and NP/Physician have been notified and the documentation of the notification is present in the medical record. Corrections will be made immediately as applicable. 4. Audits will be conducted by the Director of Nursing or the Assistant Director of Nursing 5 days a week for four (4) weeks and then weekly for 4 weeks to ensure RP, Nurse Practitioner or Physician is notified. Findings of the audits will be addressed in Quality Assurance and Performance Improvement Committee (QAPI) meeting for a minimum of three months by the Administrator for review and interventions as necessary beginning with March's QAPI meeting on March 19, 2024.	

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F 580	Continued From page 3	F 580		

changes in her except for the hematoma to her forehead. She revealed that the NP suggested that resident go on to dialysis since she checked out okay because she really didn't need to miss this. The ADON revealed that her Resident Representative (RR) came in just before the NP assessed Resident #1 and was then made aware of the fall. The ADON revealed they started investigating the incident immediately and found out that a Certified Nursing Assistant had walked across from another hall and saw the resident on the floor, reported it to the nurse on duty and she assessed her, and the resident was assisted back into bed. She revealed that 24 hours later on 01/18/24, Resident #1 was tired, more lethargic and wasn't eating, so they sent her out to the Emergency Room to be evaluated since they had knowledge of the fall. She revealed that Resident #1 was sent back to the nursing home that same day with no negative findings. She stated their protocol after a fall was for the resident to be assessed, for the nurse to report it to the Nurse Practitioner and to notify the family. She revealed that the nurse on duty that night had not contacted the RR to inform them of the fall. She confirmed that the On-Call Nurse Practitioner nor the family had not been notified of the fall.

On 02/13/24 at 9:30 AM, a phone interview with Resident's sister (RR), revealed that she came into the facility to check on Resident #1 every day and on the morning of 01/17/24, saw that Resident #1's eyes were black, and she had a big knot on her head. She stated, "They were supposed to call me if anything happened to her."

On 02/13/24 at 9:50 AM, an interview with the Administrator (ADM), revealed that they found out

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F 580	Continued From page 4	F 580		

during the investigation that there was no family contact information in the computer at the time of the fall under Resident #1's file. The ADM revealed that it was protocol with any fall to assess the resident, call and let the resident's family (RR) know. The Administrator confirmed that the RR was not notified of the fall and that the contact information was not entered into the system by the Admission Coordinator.

On 02/13/24 at 10:10 AM, an interview with the Admissions Coordinator revealed that it took Resident #1's family a couple extra days to come in and sign her paperwork and she failed to enter the rest of her information which included her contact information. She stated, "I own it, it was my fault for not getting the contact information in." The Admission Coordinator revealed that the referral information had been uploaded under documents, but the nurse would not necessarily know to look there. She revealed that this was the first time she had missed getting the information entered under contacts and when she realized it, she went immediately and fixed it. She stated, "Going forward, everyone will have contacts entered." She revealed that they sometimes had more than one admission at a time, and she guessed it slipped through the cracks.

Record review of Resident #1's "Admission Record" revealed an admission date of 01/11/24 with the following diagnoses to include: Sickle-Cell Thalassemia, Weakness, Acute on Chronic Diastolic Congestive Heart Failure, Dependence on Renal Dialysis, End Stage Renal Disease, and Chronic Obstructive Pulmonary Disease.

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F 580	Continued From page 5 Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/18/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 02 which indicated that she had severe cognitive deficits.	F 580		