STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

(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 Survey Agency (SA) conducted an annual recertification from 10/2/18 through 10/4/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F641 and F761. At the time of the survey, the census was 53 and the facility held a license for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for Resident #16's medications, and Resident #10's suprapubic catheter, for two (2) of 18 MDS assessments reviewed. Findings include: Review of a typed statement on the facility's letterhead, no date, title, or signature, revealed: "Our policy for completing the MDS is the Centers for Medicare & Medicaid Services Long Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0 User's Manual, version 1.14. Resident #16	F 641	1. The MDS for Resident #16 ARD of 08/06/2018 was modified and submitted successfully. All resident's MDS on anticoagulants including aspirin and clopidogrel were audited for the last quarter of assessment for accuracy. Any discrepancies have been modified and submitted successfully. Audit completed by R.N. 10-05-2018. 2. An audit was conducted of all residents that coded for anticoagulants for verification that the resident had indeed received anticoagulants during the look back period. We removed the coding for anticoagulant and replaced coding with a "0" for all residents that had not received an anticoagulant for during the look back period. An audit was conducted of all residents with a foley and no additional	11/9/18

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

Electronically Signed — 11/01/2018

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 641	Continued From page 1 Record review revealed, Resident #16's most recent Quarterly MDS assessment, with an Assessment Reference Date (ARD) of 08/06/18 Section N for Medications was coded to include an anticoagulant. Review of the Medication Administration Record (MAR) dated August 2018, revealed Resident # 16 did not take an anticoagulant medication. On 10/3/18 at 11:05 AM, an interview with Registered Nurse (RN) #1 revealed, RN #1 stated, "if the medication was Plavix or Aspirin, I was not supposed to code it as an anticoagulant." RN #1 also stated, she uses the Resident Assessment Instrument (RAI) Manual to complete the MDS. RN #1 stated she would complete a modification for the Quarterly MDS assessment with an Assessment Reference Date (ARD) of 08/06/18. A review of the facility's Face Sheet revealed, Resident # 16 was admitted by the facility, on 5/2/18, with the included diagnosis Atherosclerotic Heart Disease. Resident #10 Record review Resident #10's Treatment Review Record (TAR), for October 2018, revealed the following treatment: Empty Suprapubic catheter and record output three times a day, order date 07/17/18. Resident has indwelling Suprapubic catheter 16 Fr. 10 cc (cubic centimeters) balloon related to a diagnosis of Neurogenic Bladder and Bladder Spasms, frequent Urinary Tract Infections (UTIs). Perform catheter care routinely with mild soap and water. Monitor for s/s (signs	F 641	discrepancies were found. 3. All residents with orders for anticoagulants are at risk for the deficient practice. 4. All MDS's for residents that are on anticoagulants including aspirin and clopidogrel will be audited by medical records for accuracy before submission of each assessment. MDS nurse is to provide medical records with a MDS schedule and medical records is to review all residents on anticoagulants and review these assessments for accuracy. This will be completed weekly x 4 weeks and then on a monthly basis. 5. This will be discussed and documented in monthly QAPI x 2 months for assessment and evaluation. Audit will be documented on flowsheet to show proper monitoring of MDS accuracy. 1. The MDS for resident #10 ARD 07/24/2018 was modified and submitted successfully. All resident's MDS that have a urinary catheter were audited for the last quarter of assessments for accuracy. Any discrepancies have been modified and submitted successfully. Assessment completed by R.N. 10-05-2018. 2. All residents with urinary catheters are at risk for the deficient practice. 3. All MDS's for residents that have urinary catheters will be audited by medical records for accuracy before submission of each assessment. MDS nurse is to provide medical records with a	

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F 641	Continued From page 2 and symptoms) of infection such as elevated temp, odor, blood in urine, leaking tubing. Notify physician for s/s of infection, order dated 07/23/18. Review of the October 2018 Medication Administration Record (MAR) revealed: Monitor Suprapubic catheter and make sure catheter bag is covered at all times and leg band in place at all times, order dated 07/17/18. Review of the most recent Comprehensive MDS, assessment with an ARD of 07/24/18, revealed section H0100-B was coded yes for an external catheter. Review of Resident #16's Comprehensive Care Plan revealed a Focus, dated 07/20/18, for Urinary Tract Infection actual and risk due to a history of Chronic Urinary Tract Infections, use of a Suprapubic catheter and diagnosis of Neuromuscular Dysfunction of the Bladder. Further review of the Care Plan revealed the Focus, dated 07/23/18, for Alteration in elimination of bowel and bladder indwelling Urinary catheter (Suprapubic catheter) and incontinent of bowel. On 10/02/18 10:35 AM, an interview with Resident # 10, revealed she has the catheter because every time she would stand, the urine would just pour out. Resident # 10 also stated she has a history of UTIs. On 10/03/18 at 3:15 PM, an interview with the Director of Nurses (DON), revealed she does not think Resident # 10 has had an external catheter since she has been in the facility. The DON also stated Resident # 10 was admitted with a	F 641	MDS schedule and medical records is to review all residents that have an urinary catheter and review for accuracy. This will be completed weekly x 4 weeks and then on a monthly basis. 4. This will be discussed and documented in monthly QAPI x 2 months for assessment and evaluation. Audit will be documented on flowsheet to show proper monitoring of MDS accuracy.	

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F 641	Continued From page 3 suprapubic catheter, and goes to the Urologist clinic in Jackson. The DON stated she would say, the MDS nurse would need to code the MDS based on what she assesses. The DON stated the coding of an external catheter for Resident # 10 is not accurate. On 10/03/18 at 3:35 PM, an interview with RN #1, revealed Resident #10 does not have an external catheter, and only has a suprapubic catheter. RN #1 also stated the admission MDS assessment is not coded accurately. On 10/03/18 at 4:00 PM, an observed revealed RN #2 performed Suprapubic catheter care on Resident # 10. RN #2 used good infection control techniques, washing hands as appropriate, and changing gloves as needed. A review of the facility's Face Sheet revealed, Resident #10 was admitted by the facility, on 07/17/18, with the included diagnosis Neurogenic Bladder.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		11/9/18

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F 761	Continued From page 4 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to properly store drugs and biologicals, as evidenced by expired medications stored in the medication room for one (1) of one (1) medication rooms observed. Findings include: Review of the facility's policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles", with a revision date of 10/31/16, revealed: 17. Facility personnel should inspect nursing station storage area for proper storage compliance on a regularly scheduled basis. 18. Facility should request that Pharmacy perform a routine nursing unit inspection for each station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals. An observation of the Medication Room, on 10/03/18 at 9:47 AM, with Licensed Practical	F 761	1. All OTC stock medications in the medication carts were checked on 10-03-2018 and no expired medications were noted. The medication supply room was also checked 10-03-2018 and any expired medications that were noted were removed and destroyed according to center protocol. This was audited and completed by R.N. on 10-03-2018 2. All residents in the center are at risk for the deficient practice. 3. Matchback of medication carts are to take place weekly and documented by nurses. This includes checking for expiration dates of OTC medications in the medication carts. Medical Records/Central Supply nurse will check all OTC medications in the cabinet in the medication room on a weekly basis x 4 weeks and then monthly. Documentation of this being completed will be turned into the director of nurses weekly x 4 weeks then monthly. 4. This will be discussed and	

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F 761	Continued From page 5 Nurse #1 (LPN) revealed the following medications had expired: Oscal with Calcium Plus D3 (51 tablets) expired June 2018, two (2) bottles Vitamin E 100 Softgels expired November 2017, two (2) bottles Vitamin E 100 Softgels expired 9/18, Vitamin D3 400IU expired 12/16 (19 tablets), Vitamin E 400 IU 77 softgels expired 9/2018. There was no Vitamin E or Vitamin D3 available for immediate use. An interview with LPN #1, on 10/03/18 at 10:05 AM, revealed she was going to discard all expired medications. LPN #1 stated the Medical Records Nurse was responsible for checking the medication room for expired medications, and ordering medications. An interview with the Director of Nursing (DON), on 10/03/18 at 10:20 AM, revealed she stated the Medical Records Nurse was responsible for checking for expired meds on a monthly basis. The DON stated the Medical Records Nurse was out at the present time on surgical leave. The DON stated she was not aware there were any expired meds, but she would make sure they were discarded. The DON stated she had checked all the med carts to make sure they were ok. The DON stated the Pharmacy Consultant checks the med carts monthly, and occasionally checks the medication storage room.	F 761	documented in monthly QAPI x 2 months for assessment and evaluation. Audit will be documented on flowsheet to show proper monitoring of OTC medications being monitored for expiration dates.	

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	255175	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/03/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 11/01/2018

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 10/03/2018 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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