STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

(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 #24852 and CI MS #25031 at the facility on 5/8/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F684 related to CI MS #24852 for failure to provide services in accordance with professional standards of practice. There were no deficiencies cited for CI MS #25031 related to discharge. The census at the time of the survey was 123 with a bed capacity of 140 beds.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and Resident Representative (RR) interview, record review and Administrator statement review the facility failed to ensure a resident received treatment and services in accordance with professional standards of practices as evidenced by failure to change the negative pressure wound therapy system dressing as ordered by the provider for one (1) of three (3) residents with wound care reviewed.	F 684	Resident #1 discharged home with daughter on 4/11/2024. All residents with wound care orders have the potential to be affected by deficient practice. All residents with treatment orders were reviewed by the Director of Clinical Operations (DCO) on 5/8/2024 to ensure	6/3/24

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

Electronically Signed | 05/21/2024

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F 684	Continued From page 1 Resident # 1 Findings include: Record review of a typed document, undated, on facility letterhead and signed by the Administrator revealed "(Proper Name of Facility) utilizes Negative Pressure Wound Therapy System manufactures guidelines." Record review of the NEGATIVE PRESSURE WOUND THERAPY SYSTEM (NPWT) "Instructions for Use" revealed " ...The NPWT system should remain on and in use for the duration of the prescribed treatment..." During a telephone interview on 5/8/24 at 10:00 AM, with Resident # 1's RR, she stated she notified the facility staff that Resident #1's wound vac dressing to the left abdominal wound needed to be changed. She stated she was told that the dressing is only changed if the suction "broke". She stated that the facility did not remove Resident #1's abdominal dressing the week of 04/01/24 until 4/10/24 and at that time the foam from the dressing was adhered to the wound. Record review of the "Order Summary Report" with active orders as of 3/26/24 revealed an order dated 3/26/24 "Treatment; Surgical wound to left lateral abdomen (#4) Clean with NS (normal saline), apply wound vac at 125 mmHg (millimeters of mercury) every Monday and Thursday PRN (as needed) for drainage/dislodgement ..." Record review of the April 2024 electronic treatment administration record (eTAR) for Resident #1 revealed there was no	F 684	licensed nurses had documented treatment administration for past 24 hours. On 5/9/2024, the Director of Clinical Education provided education to licensed nurses on providing treatments as physician ordered with documentation of treatment provided in E-TAR (Electronic-Treatment Administration Record). Beginning on 5/9/2024 the Director of Nursing Services (DNS)/Unit Managers/Registered Nurse/Charge Nurse will review treatment documentation daily to ensure compliance with treatments and documentation. To monitor the performance of our corrective action and to ensure sustainability, the Director of Nursing, Unit Managers and/or Registered Nurse/Charge Nurse will audit TARS (Treatment Administration Record) five times a week for four weeks and then three times a week for eight weeks, to ensure documentation of treatments provided to residents per physicians' orders beginning 5/8/2024. Starting on 5/13/2024 the Director of Nursing Services, Unit Managers, and/or Director of Clinical Education will obsrve Licensed Nurses providing wound care to ensure physician orders are followed three times a week for twelve weeks. The Director of Clinical Operations will audit weekly for twelve weeks beginning 5/14/2024, the TARS (Treatment Administration Record) for any missed documentation. Any	

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F 684	Continued From page 2 documentation that the wound vac dressing was changed on 4/1/2024, 4/4/2024 or 4/8/2024. Record review of "General Notes" for Resident #1, dated and timed 4/10/24 at 1:33 PM, revealed "Wound vac dressing removed from left lat (lateral) abdomen ...Lower wound remains open. Foam dressing adhered to wound bed ..." Record review of "Progress Note Details" for Resident #1 dated 4/11/2024, completed by Wound Care Nurse Practitioner (NP) revealed, " ...The wound vac was last changed on 3/25/24 and removed by the facility NP and DON (Director of Nursing) on 4/10/24 with sponge fragments remaining in the wound ...The site was debrided today removing ...fragments ...Not all fragments were able to be removed ...Recommend dressing changes ...until evaluated by surgeon ..." In an interview with Registered Nurse #1 (RN) on 5/8/24 at 12:30 PM, she stated that the resident's RR notified her that the wound vac dressing needed to be changed, but she was unsure of the date she was notified. She stated that she observed the abdominal wound vac dressing at that time and it looked like it needed to be changed. She stated she did not recall the date on the dressing. RN #1 stated that the previous DON was responsible for wound care at that time, and she notified her that the dressing needed to be changed. RN #1 verified that the eTAR for April 2024 had no documentation that the wound vac dressing had been changed and that if there was no documentation, then it was not performed. Interview with NP #1 on 5/8/24 at 12:45 PM, she verified that she was informed by the previous	F 684	negative findings of the audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator and/or the Director of Nursing for review and corrective action as necessary beginning with May's Quality Assurance Performance Improvement Committee Meeting on May 28, 2024.	

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F 684	Continued From page 3 DON on 4/10/24 that the foam from the wound vac dressing was adhered to the residents wound bed. She stated upon her assessment of the abdominal wound on 4/10/24 that the foam from the dressing was adhered to the wound bed and they were unable to remove it. She verified that failure to change the wound vac dressing as ordered could cause the foam to be adhered to the wound and prevent healing. In an interview with the Administrator on 5/8/24 at 2:00 PM, he agreed Resident #1's wound vac dressing should have been changed as ordered. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 3/25/24 with a diagnoses that included Unspecified open wound of the abdominal wall.	F 684		