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 06/12/2024

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 #24744, CI MS #24745, CI MS #24944, CI MS #24945, CI MS #24947, CI MS #25168 and CI MS #25260 at the facility from 06/11/24 through 06/12/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI MS #24945, CI MS #24947, CI MS #25168, and CI MS #25260 for improperly dressed residents, infection control concerns, and poor food quality and there were no deficiencies cited. The SA investigated CI MS #24744, CI MS #24745, and CI MS #24944 for residents not treated with dignity and respect, not answering call lights timely, incontinence care, medications left unattended, residents not receiving baths, residents not groomed adequately and cited M500 and M610. At the time of the survey the facility held a census of 97 and was licensed for 119 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;	M 500		7/15/24

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M 500	Continued From page 1 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice	M 500		

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M 500	Continued From page 2 grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full	M 500		

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M 500	Continued From page 3 recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M 500		

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M 500	Continued From page 4 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to ensure that a resident was treated with dignity when she asked for assistance with toileting and a staff member refused for one (1) of eight (8) residents reviewed. Resident #1. Findings Include: Record review of the facility policy, "Resident's Rights and Quality of Life" dated May 1, 2012, revealed "It is the policy of Advocate that all residents have the right to a dignified existence, self-determination, and communication with an access to people and services inside and outside the facility..." On 06/11/24 at 10:30 AM, an observation and interview with Resident #1 revealed her sitting in a wheelchair propelling herself in her room. She revealed that she was not able to walk, that she wore briefs and required help to use the bathroom. She revealed that she pressed the call light when she needed her brief changed and they usually came within a few minutes. Resident #1 stated, "I'm so tired of pissing my clothes." Resident #1 revealed that when she asked for help to the bathroom, the Certified Nursing Assistants (CNAs) often told her they "didn't have	M 500	1. On 6/11/24, Resident #1 was assisted to toilet by direct care staff utilizing the sit-to-stand lift. On 6/11/24, Certified Nursing Assistant (CNA) was inserviced by the Administrator and Director of Nursing regarding the facility policy for "Dignity" and "Resident Rights." 2. All residents have the potential to be affected by this practice. 3. Beginning 06/14/24, the Director of Nursing began in-servicing direct care staff regarding the policy for "Dignity" and "Resident Rights". 4. Beginning the week of 6/17/24, the Administrator, Director of Nursing, and Assistant Director of Nursing began monitoring rounds during resident care of five residents to assure residents assisted to toilet as care planned. Monitoring rounds to be conducted three times weekly for four weeks, two times weekly for four weeks, then weekly for four weeks. Beginning the week of 6/24/24, the Social Services Director and Director of	

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M 500	Continued From page 5 time for all that" and that it was "too much trouble" for them. Resident #1 also revealed that someone had once told her to go ahead and use the bathroom in her diaper and they would change her later. She revealed that she was fifty-three years old and stated, "I don't feel right about doing that, especially having a bowel movement because it messes my clothes up." Resident #1 revealed that she would rather go into the bathroom and use the commode. Resident #1 revealed that she had a hard time standing because her left leg didn't work too well but they had a sit to stand lift they used to help her on the toilet. Resident stated, "I need to pee now." At 10:34 AM, observed Resident #1 press her call light to ask for assistance with toileting. At 10:38 AM, CNA #1 entered Resident #1's room and asked her what she needed. While the State Agency was standing in the room, Resident #1 asked CNA #1 to help her go to the bathroom and CNA #1 stated, "I can't help you with that." A brief interview with CNA #1 revealed that Resident #1 usually went to the bathroom in her brief and they changed her afterwards. CNA #1 stated, "I'm sorry" and revealed that she should have helped her go to the bathroom when she asked and that she would "take her now." On 06/11/24 at 10:45 AM, an interview with Licensed Practical Nurse (LPN) #1, revealed that CNA #1 should have assisted Resident #1 to the bathroom when she asked. She revealed that she would report the incident to the Director of Nursing (DON) right away. She revealed that it was unacceptable behavior to refuse to meet a resident's needs. On 06/11/24 at 10:50 AM, an interview with DON revealed that when any resident asked for help to the bathroom, the CNAs were supposed to help	M 500	Care Coordination will conduct five resident interviews weekly for twelve weeks to assure no concerns noted with toileting assistance. Any negative findings will be addressed at that time. Findings of monitoring will be brought to the Quality Assurance Performance Improvement Committee for review and recommendations on 07/08/2024, then monthly for three months.	

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M 500	Continued From page 6 them. The DON agreed that refusing to take a resident to the bathroom when asked and telling a resident to use the bathroom in their brief was a dignity issue and they would not tolerate this. On 06/11/24 at 11:15 AM, an interview with Administrator revealed that it was not acceptable behavior for any staff member to tell a resident to "go in their brief, and they would change them later." She revealed that Resident #1 always used the bathroom, and that CNA #1 should have helped her to the bathroom when she asked to go. Record review of Resident #1's "Admission Record" revealed an admission date of 09/14/2023 and her diagnoses included Reduced Mobility and Need for Assistance with Personal Care. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/13/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she had no cognitive deficits.	M 500		
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	M 610		7/15/24

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M 610	Continued From page 7 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review the facility failed to provide oral care for a resident (Resident #8) and failed to shave residents (Resident #1 and Resident #8) for two (2) of eight (8) residents reviewed. Findings Include: Record review of the facility policy, "ADL's (Activities of Daily Living)" dated August 2021, revealed, "Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodations of the resident's choices and preferences..." RESIDENT #1 On 06/12/24 at 10:20 AM, an observation and interview with Resident #1 revealed facial hair, one approximately two (2) inches long on her left lower jaw and there was an area approximately three inches by three inches with scattered black hairs that measured approximately one-half inch to three-fourths inch on her lower chin. Resident #1 revealed that she didn't like to have facial hair and wanted it gone. She revealed that the Certified Nursing Assistants (CNAs) had shaved it before but hadn't lately. She stated, "I don't like to have hair on my face, and I want it off." On 06/12/24 at 10:40 AM, during an observation and interview Licensed Practical Nurse (LPN) #2 confirmed the facial hair on Resident #1's left	M 610	1. On 06/12/24, Resident #1 was shaved by Licensed Practical Nurse #2. On 06/12/24, Resident #8 was provided toothbrush and toothpaste and assisted with oral care and shaving by direct care staff. 2. All residents have the potential to be affected by this practice. 3. Beginning 06/14/24, the Director of Nursing began inservicing direct care staff regarding the comprehensive care plan and care delivery. 4. Beginning the week of 06/24/24, the Administrator and Director of Nursing will conduct observaton rounds with accompanying audit of 10 resident's Activities of Daily Living (ADL) documentation to assure care documented in accord with the care plan. Additionally, the Administrator will conduct five resident interviews to assure care plan compliance and accuracy of care delivered. Audits and observation rounds will be conducted two times a week for four weeks, then weekly for eight weeks. Any negative findings will be addressed immediately. Findings of monitoring will be brought to the Quality Assurance Performance Improvement	

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M 610	Continued From page 8 lower jaw and chin. LPN #2 revealed that Resident #1's facial hair should have been removed on Monday, 06/10/24, when the CNAs gave her bath. She revealed that the CNAs had a bath sheet they filled out with every bath, and they had to check off what they completed unless the resident refused and if refused, they had to mark refused to that particular care area. Resident #1 stated to LPN #2, "I don't want it refused, I want it shaved." Record review of Resident #1's "POC (Plan of Care) Response History" form revealed that she received a shower on 06/10/2024 prior to this survey entrance on 06/11/24. Record review of Resident #1's "CNA (Certified Nursing Assistant) Bath & Shower Report" revealed that the CNA marked "No" on "Facial Hair Removed" on 06/10/24. Record review of Resident #1's "Admission Record" revealed an admission date of 09/14/2023 and her diagnoses included Reduced Mobility and Need for Assistance with Personal Care. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date of 03/13/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that she had no cognitive deficits. RESIDENT #8 On 06/12/24 at 9:15 AM, an observation and interview with Resident #8 revealed him lying in bed. He revealed that he received his baths about three times a week and had been shaven only once since he'd been here. An observation	M 610	Committee for review and recommendations 07/08/24, then monthly for three months.	

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M 610	Continued From page 9	M 610		

revealed facial hair approximately three-fourths to one inch long covering his upper lip and a beard with hair approximately one-half inch long covering his bilateral facial area and chin. Resident #8 revealed that while he was at home, he shaved two to three times a week. He stated, "I would like to be shaved more often." He revealed that he also needed a toothbrush and some toothpaste so he could brush his teeth. Resident #8 revealed that he had not brushed his teeth since had had been admitted, which was over a week ago and he had been asking for a toothbrush and toothpaste and no one had provided these for him. An observation of Resident #8's teeth revealed white substance between his upper teeth and gumline.

On 06/12/24 at 9:40 AM, an interview with CNA #2 revealed that they were supposed to provide mouth care to residents every day and that they shaved resident's facial hair when they provided their baths or showers. She revealed that if a resident could brush their own teeth, the CNAs assisted them with set up as needed and cleaned up afterwards. CNA #2 revealed that when a newly admitted resident came into the facility, they provided them with a wash basin, mouthwash, and toothbrush and toothpaste if these items were not brought from home. CNA #2 also revealed that if a resident refused mouth care, they were supposed to report it to the nurse.

On 06/12/24 at 9:50 AM, an interview with CNA #3 revealed that they had a bath sheet they had to fill out on each resident and had to mark what care area was completed and what was refused. CNA #3 revealed that she was assigned to A-Hall today and confirmed that she had not assisted Resident #8 with mouth care today.

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M 610	Continued From page 10 On 06/12/24 at 9:55 AM, an interview with CNA #4 revealed that shaving was included in personal care and was supposed to be completed during residents' scheduled bath or shower time. She also revealed that resident mouth care was supposed to done every day. On 06/12/24 at 10:30 AM, an observation and interview with LPN #2 revealed that Resident #8 received his bath three times a week. She revealed that on bath days, the CNAs were responsible for bathing, nail care, and shaving facial hair unless the resident refused. LPN #2 revealed that the CNAs also were responsible for mouth care every day. She revealed that if a resident could brush his or her own teeth, the CNAs assisted with set up and they cleaned up afterwards. LPN #2 confirmed the white substance between Resident #8's upper teeth and confirmed his facial hair which was approximately one-half inch long and his mustache which was approximately one inch long. Resident #8 stated to LPN #2, "I shaved two or three times a week at home, and I haven't been shaved but one time since I've been here." He revealed that he had not been able to brush his teeth since he'd been here in the facility because he didn't have a toothbrush or toothpaste and also stated to LPN, #2, "I've been asking for these things since I got here." LPN #2 stated to Resident #8 that she would get the CNAs to shave him today and she would get him toothpaste and a toothbrush together now. On 06/12/24 at 10:50 AM, an interview with DON confirmed that facial hair on men and ladies should be addressed during their regular scheduled bath time. She also confirmed that Resident #8 should have been shaved on Monday, 06/10/24, when he got his shower and	M 610		

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M 610	Continued From page 11 should have received a toothbrush and toothpaste and been assisted with mouth care every day since admission. Record review of Resident #8's MDS with ARD of 06/07/2024 under Section GG revealed that he required supervision or touching assistance to complete oral and personal hygiene including combing hair and shaving. Section C revealed a BIMS Score of 10 which indicated that he had moderate cognitive deficits. Record review of Resident #8's "POC Response History" form revealed that he received a shower on 06/10/2024 and review of his "CNA Bath & Shower Report" revealed that "Facial Hair Removed" was marked "No." Record review of Resident #8's "Admission Record" revealed an admission date of 05/31/2024 and had diagnoses that included Myelodysplastic Syndrome and Need for Assistance with Personal Care.	M 610		