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	255117	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations at the facility from 8/26/24 through 8/29/24. (CI) MS #26214 was investigated and the SA found the facility to not be in compliance and cited F550, F677 and F692.CI MS #26299 was investigated and the SA found the facility to not be in compliance cited F656 and F742. CI MS #26316 was investigated and no deficiencies were cited related to this CI. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F565, F641, F656, F677, F688, F761, F804, F809. The census at the time of the survey was 113 and the facility was licensed for 119 beds.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		10/7/24

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

Electronically Signed | 09/16/2024

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure that a resident's rights were honored when a staff member refused to assist a resident with toileting for one (1) of four (4) survey days. Resident #2 Findings include: Review of the facility policy titled, "Resident Rights & Quality of Life", with an effective date of March 13, 2020, revealed, "...It is the policy that all residents and patients have the right to a dignified existence, self-determination, and	F 550	On 8/27/24 the resident was assisted to the bathroom by the Certified Nursing Assistant (C NA) and Registered Nurse (RN) per direction of the Director of Nurses (DNS). The nurse assessed Resident #2 for emotional and or physical harm/discomfort with no negative outcome noted. Resident #2 was educated on our misunderstanding of the practice, and we apologized. Resident # 2's care plan was reviewed with no changes necessary. All residents requiring assistance with	

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F 550	Continued From page 2 communication with access to people and services inside and outside the center..." An observation and interview on 8/27/24 at 12:00 PM, revealed Resident #2 sitting in her wheelchair in her room. Resident #2 stated "My bladder is about to bust. I've got to go to the bathroom so bad. I just returned from an appointment and haven't been to the bathroom since leaving the facility this morning." The resident was observed using her call light to ask for help. The resident stated "they won't do it right now. They always say they can't while they are passing out trays." The resident kept urgently saying, "Oh, I've got to go so bad." Resident #2 engaged her call light, and Registered Nurse (RN) #1 entered the room; the resident stated, "Please, I've got to go to the bathroom so bad!" Registered Nurse (RN)#1 stated to the resident, "They can't right now. They are passing trays." When asked why they couldn't assist the resident in going to the bathroom, she stated, "We've always been told we can't take anyone to the bathroom during meals or passing trays." Requested the Director of Nurses (DON) to come to the resident's room, so RN #1 left the room to go get the DON, but neither the nurse nor the DON came back to the room. An interview with the DON at 12:07 PM, in her office revealed we can't change or toilet residents while they are feeding other residents. She stated " I will have to look at the cross-contamination policy as to the reason why." She revealed that she knew the resident had the right to go to the bathroom when needed, but that she would have to look at the policy first. The DON then instructed RN #1 to take the resident to the shower room to use the bathroom.	F 550	toileting may potentially be affected by this practice On 8/27/24, the DNS assured that the nursing staff conducted a 100% audit with all other incontinent residents to assure they were toileted if needed. On 8/27/24, Director of Nurses and Director of Clinical Education (DCE)initiated an in-service with the direct care team on resident's rights with an emphasis on honoring a resident's request to toilet, regardless of the time of day. On 8/27/24, the Director of Clinical Operations (DCO) reviewed the Diversicare infection control policies and guidelines and determined there were no amendments necessary. On 08/27/2024 education was provided by the Director of Clinical Operations to the Director of Nurses (DNS) to assure understanding that we are responsible for toileting the residents as needed and upon request and this includes during meals if necessary. On 08/27/2024 the DNS and or DCE educated the nursing team on respecting the dignity of each resident with providing care in accordance with requests and needs with the understanding that refusing to toilet during mealtimes is unacceptable. A resident council meeting to be held 9/17/24 to inform residents that staff will provide toileting assistance during mealtimes. On 08/27/2024 the Administrator began	

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F 550	Continued From page 3 An interview on 8/27/24 at 12:20 PM, Certified Nurse Aide (CNA) #1 revealed we are not supposed to toilet residents during mealtimes. She stated "it gets us in trouble with the residents because we have to tell them that we can't change them because we could get in trouble for doing it during mealtime." She revealed that we were told that it is a "state thing" and that if the state came into the building and we were changing someone or taking them to the bathroom, we would get in trouble. In an interview on 8/27/24 at 12:25 PM, CNA #8 revealed "We have always been told that we are not allowed to take anyone to the bathroom or change anyone's briefs during mealtime. They have always just said because it is cross-contamination." In an interview on 8/27/24 at 2:20 PM, the DON revealed I have started doing in-services to all the staff on the floor and stated, "Using the bathroom trumps everything; they have a right to be changed and assisted to the restroom at any time." Record review of Resident #2's "Admission Record" revealed an admission date of 02/23/2022 with medical diagnoses that included Overactive bladder,Type 2 Diabetes Mellitus, and Heart failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/24, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 550	an audit of a minimum of 5 residents weekly x 4 weeks then monthly x 2 months of alert and cognitively intact residents who require assistance with toileting to assure that staff are providing assistance if requested. Monitoring of the provision of toileting assistance during mealtimes will be highlighted in the monthly resident council meeting beginning on 09/17/24 for a minimum of 3 months by specifically inquiring if resident's requests to be toileted was provided timely. These audits and monitoring activities will be addressed it the overall Quality Assurance Performance Improvement plan in September for a minimum of 3 months to assure continued compliance.	

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F 565	Continued From page 4	F 565		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 565		10/7/24

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F 565	Continued From page 5 Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve grievances related to food concerns and bed linens not being changed for five (5) of seven (7) residents with grievances. Resident #3, #19, #26, #88, and #108. Findings Include: Review of the Facility policy titled "Customer Concern (Grievance) Policy" dated 7/2018, revealed "Purpose: Support each customer's (patient's/resident's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately apprised of its progress toward resolution ...Process... The Administrator will ensure a thorough investigation is conducted and will respond to the customer (patient/resident) .... The Administrator shall follow up on the correction of the problem and finalize the Customer Concern Form validating the resolution of the concern including who did what, when, and where .... It is best practice for the Administrator to follow up with the customer after a period of time to ensure the customer remains satisfied with the concern resolution. This follow up should be recorded on the log. Maintaining evidence demonstrating the results of all grievances ..." Record review of the "Customer Concern/Grievance Communication Form" dated 7/30/2024 revealed Resident #26 filed a grievance regarding the quality of food services and presentation of meals specifically with egg salad. Revealed under, "Steps Taken to investigate Concern: Spoke with Dietary Manger; staff educated on service, presentation of meals".	F 565	Residents # 3, 19, 26, 88 and 108 where each interviewed by the Director of Nurses on 8/29/24 for grievances regarding preferences, including likes, dislikes and concerns about food. Residents # 19 and # 108 were each interviewed by the Director of Nurses on 8/29/24 for grievances regarding resident's sheets to assure they were clean or changed if needed. The sheets were changed as needed. On 8/29/24 the administrator educated the Activities Director and Social worker on grievance process with an emphasis on resolution. All residents have the potential to be affected by this practice. 100% of all grievances received over the past 3 months were audited to assure resolution had been executed. No additional unresolved resolution noted. Administrator was educated on the grievance process on 8/29/24 by the Director of Clinical Operations. Going forward, systemic changes include that all grievances will be logged and tracked specifically for timely resolution. Beginning on 8/29/24 the Administrator conducted and in-service to our leadership team which consists of Director of Nurses, Assistant Director of Nurses, Business Office Manager, Social Worker, Maintenance Director, Maintenance Assistant, Health Information Management Coordinator, Unit Managers, Activities Director, Director of Clinical	

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F 565	Continued From page 6 The grievance was marked as resolved. An interview on 8/27/2024 at 11:45 AM, with Certified Nursing Assistant (CNA) #1 revealed the residents complain all the time about the food. I have told the residents to talk about it in resident council when they go, when they come back from resident council they will tell us that they told them about the food. She revealed it has been a problem and everyone knows about the food issues. A resident council meeting was held on 8/27/2024 at 3:05 PM in which Resident #3, #19, #88, and #108 all revealed food concerns were discussed every month in resident council meetings, and they had not seen anything done to address their concerns. During the meeting Resident # 108 revealed the residents do not have food choices. She explained they had a set menu, and they can only get what was on the menu or two alternates to choose from every day, which is either a hamburger or a chicken sandwich. She stated, "I'm a vegetarian and so is my roommate, and they don't have options for us." She revealed the food was disgusting and had no seasoning or flavor. Furthermore, she explained that she had been served lunch before and the next day was served the exact same thing for lunch and supper. She revealed the food was always cold and stated the vegetables were watery and ran together with other foods on the plate. Resident's #3 and #19 revealed the cornbread was so flat and hard there was no way to chew and swallow it. Resident # 88 revealed he was served mashed potatoes almost every day. He explained the vegetable medley and green beans were watery and agreed with Resident #108 that it merged with other foods on the plate. Resident#108	F 565	Education, Registered Nurse Assessment Coordinator, Receptionist, Director of Care Coordination and Human Resource Coordinator on the new process of tracking grievances and timely resolution. The Administrator will receive Resident Council minutes and transpose the concerns onto grievance forms. The Social worker will follow up within 7-10 days on the completed grievances. All grievances will be reviewed the following month in Resident Council to assure resolution. Resolution to each grievance will be documented on or attached to the grievance form. Beginning 8/29/24, the administrator will conduct an audit of grievances for resolution weekly x 4 weeks and monthly x 2 months. This issue will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI in September to assure continued compliance. Any variance will be addressed immediately.	

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stated the food was as though they just threw something together and occasionally the foods were not cooked thoroughly. Resident #19 and #108 confirmed they had received foods that were not cooked thoroughly before. All resident voiced they had spoken about these food concerns in resident council with the Activity Director, the Dietary Manager and the Administrator in attendance. Resident #19 brought up his sheets were not being changed but about every 2 weeks. He revealed he asked them to change them, but usually, it does not get done because they say they are busy. Resident #108 stated her linens get changed only when her room gets deep cleaned which was twice monthly. The resident's voiced they would like to have their linen changed on their shower days.

On 8/27/2024 at 4:07 PM, an interview with the Dietary Manager (DM) revealed, she was aware Resident #26 had complaints on the food. She explained they tried to accommodate everyone but thought it was the menu the residents did not like.

An interview with Social Services (SS) #1 on 8/27/2024 at 4:20 PM revealed, Resident #26 had not voiced food concerns to her, but she was aware that the resident had voiced food concerns with several other facility staff members.

An interview with the Administrator (ADM) on 8/28/2024 at 9:39 AM, revealed, Resident #26 was particular about her food and stated, she had talked to the resident "a million times about her food issues." The ADM revealed that the resident even requested that she come and taste her food. She confirmed that she had not formerly filled out a grievance related to the resident's food

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concerns.

Record review of the "Resident Council Minutes" dated 2/15/2024, revealed under, "Old Business: Several stated sheets were still not being changed and were unsure of scheduled times to be changed. Activity Director then called for the Administrator to attend meeting, and she explained times the sheets are to be changed and answered all other concerns at this meeting with success." Also revealed under, "New Business: Dietary: Several had likes and dislikes that they wanted updated. List of names given to the Dietary Manger in Dietary for review."

Record review of the "Resident Council Minutes" dated 3/1/2024, revealed under, "Old Business" nothing was documented to address the previous concerns voiced in resident council meeting. Also revealed under, "New Business: Dietary: Everyone went over some issues with Dietary Manager about seasoning on meat and potatoes. She talked with the residents about their concerns in meeting and all were ok."

Record review of the "Resident Council Minutes" dated 4/5/2024, revealed under, "Old Business" nothing was documented to address the residents' concerns that were voiced in the previous meeting to ensure issues were resolved.

An interview with Activity Director (AD) on 8/27/2024 at 3:22 PM confirmed the residents had been reporting food concerns in the resident council meetings. She explained that most of the concerns were regarding no seasoning or flavor on the food. She revealed Resident #108 had many special requests due to her diet choices of being a vegetarian. The AD revealed after the

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meetings she gave a copy of the meeting minutes to the Administrator and the Dietary Manager for the concerns to be addressed.

An interview with the Dietary Manager on 8/27/2024 at 3:55 PM, revealed she was not aware of any recent concerns from the resident council meeting regarding food. She stated to her knowledge the residents were satisfied with the menu. The DM revealed the residents were allowed to choose between the meal on the menu or a hamburger or chicken sandwich. She confirmed she was aware of the resident complaints regarding a lack of variety of food choices.

An interview with the Administrator on 8/27/2024 at 4:10 PM, revealed she was aware of the resident concerns regarding the food. She explained the residents did complain about the food for several months in resident council back in February and March 2024, but they did not mention it again in the April meeting. She confirmed a grievance was not completed and stated she instructed the Dietary Manager to go and speak with the residents and update their likes and dislikes. The ADM revealed they have a dietary contract with "proper name" and right now, they were working at the corporate level to find a solution to the food concerns.

An interview with SS #1 on 8/28/2024 at 9:30 AM, revealed she goes to resident council meetings if she has time. She confirmed she was responsible for completing a grievance if a concern was brought to her. She revealed she was aware of the resident's food concerns and confirmed she did not complete a grievance. SS#1 stated a food complaint would be handled by the Dietary

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Department and revealed that the dietary usually goes and speaks with the resident to handle the concern. She revealed a food complaint would not be relevant to her position.

An interview with the Administrator on 8/28/2024 at 1:40 PM, revealed she was aware of resident concerns regarding the linen not being changed but thought that issue was better. She explained the last time she was invited to resident council the residents told her the linen issue was better. She confirmed there was no documentation in the resident council meeting minutes that proved anything was done to address the resident's concerns regarding the linens not being changed.

An interview with the Dietary Manager (DM) on 8/28/2024 at 2:06 PM, revealed when resident concerns were voiced in resident council about food, she personally went to speak with the residents in resident council. She confirmed that she did not have any documentation to show that the residents concerns were addressed and failed to follow up on to ensure the issues were resolved.

Resident #3

Review of the "Admission Record" revealed the facility admitted Resident #3 on 5/28/24 with medical diagnoses that included Type 2 diabetes mellitus without complications.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/6/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #3 is moderately cognitively impaired.

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Resident #19

Review of the "Admission Record" revealed the facility admitted Resident #19 on 12/23/2023 with medical diagnoses that included Mixed conductive and sensorineural hearing loss.

Review of the MDS with an ARD of 7/30/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #19 is cognitively intact.

Resident #26

An interview with Resident #26 on 8/26/2024 at 11:00 AM, revealed the food was not good and they needed to cook more vegetables. She revealed it does not do any good to talk about it in resident council because the food stays the same.

An interview with Resident #26 on 8/27/2024 at 11:05 AM, revealed, breakfast was the only decent meal she got. She explained she used to go to resident council meetings, but it did not do any good to voice her opinion. She revealed she had talked to the Administrator multiple times regarding the food and even had her take pictures of her plate. The resident stated, "I don't know if they've changed where they get their food or if there's a new crew in the kitchen; I've been here for 8 years and this is the first time I've had to say, I can't eat this."

Review of the "Admission Record" revealed the facility admitted Resident # 26 on 6/1/2021 with medical diagnoses that included Type 2 diabetes mellitus with diabetic neuropathy.

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F 565	Continued From page 12	F 565		

Review of the MDS with an ARD of 6/20/2024 revealed under section C, a BIMS summary score of 14, which indicates Resident #26 is cognitively intact.

Resident #88

Review of the "Admission Record" revealed the facility admitted Resident #88 on 2/9/2023 with medical diagnoses that included Type 2 diabetes mellitus without complications.

Review of the MDS with an ARD of 7/18/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #88 is cognitively intact.

Resident #108

During an interview on 8/27/2024 at 10:55 AM, Resident #108 revealed we discuss the food issues all the time in our monthly resident council meeting. As a matter of fact we had resident council the beginning of this month, the Administrator and the Activities Director was in the meeting. They know all about the food issues we are always complaining about it, and stated the food just does not taste good.

Review of the "Admission Record" revealed the facility admitted Resident #108 on 6/6/2024 with medical diagnoses that included Type 2 diabetes mellitus with diabetic neuropathy.

Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.

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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 interviews, record review, and facility policy review, the facility failed to accurately complete "Section N" of the Minimum Data Set (MDS) assessment for two (2) of twenty-six MDS reviewed. Resident #46 and Resident #96. Findings include: Record review of the facility policy titled, "RAI Process Guideline" dated September 2020, revealed, " ... All items in the MDS are to be coded per the instructions of the CMS Long-Term Care Facility Assessment User's Manual MDS 3.0..." Resident #46 Record review of the MDS with an Assessment Reference Date (ARD) of 07/24/24, revealed under section N, Resident #46 received seven (7) days of Anticoagulant medication for the observation look back period of 7/18/24 through 7/24/24. Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #46 did not receive anticoagulant medication between 7/18/24 and 7/24/24.	F 641	On 08/28/24 the Minimum Data Set (MDS) for residents #46 and #96 were updated to comply with the instructions under section N in the Centers of Medicare and Medicaid Long Term Care Resident Assessment Instrument manual. On 8/28/24, Vice President of Clinical Reimbursement provided an in-service to Registered Nurse Assessment Coordinators (RNAC) on identification of drug class specifically of anticoagulant and antibiotic as well as coding appropriately on the Minimum Data Set per Resident Assessment Instrument as provided. On 9/11/24 the RNAC conducted an audit of 100% of all assessments completed in last 60 days to identify any errors in coding anticoagulant/antiplatelet and antibiotics. All residents have the potential for being affected by this practice. Beginning 8/29/24 Registered Nurse Assessment Coordinator (RNAC) will have second person (partner RNAC) to review coding of anticoagulant/antiplatelet and antibiotics on all assessments prior to submission.	10/7/24

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F 641	Continued From page 14 Record review of the Admission Record for Resident #46 revealed he was admitted to the facility on 02/01/2023 with diagnoses that included Peripheral Vascular Disease, Tachycardia, and Atherosclerotic heart disease. Resident #96 Record review of the MDS with an ARD of 07/20/24, revealed under section N, Resident #96 received seven (7) days of Anticoagulant medication for the observation look back period of 7/14/24 through 7/20/24. Record review of the MDS with an ARD of 07/20/24, revealed under section N, Resident #96 did not receive seven (7) days of Antibiotic medication for the observation look back period of 7/14/24 through 7/20/24. Record review of the eMAR for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #96 did not receive anticoagulant medication between 7/14/24 and 7/20/24. Record review of the eMAR for the MDS 7-day observation look-back period revealed Resident #96 received antibiotic medication between 7/14/24 and 7/20/24. Record review of the Admission Record for Resident #96 revealed he was admitted to the facility on 11/20/2023 with diagnoses that included Cerebral infarction and Hyperlipidemia. During an interview on 08/28/24 at 8:50 AM, the MDS Coordinator confirmed that Resident #46	F 641	Admins/DNS will audit 100% of assessments weekly times 4 weeks then 50% of assessments weekly times for an additional 2 months to identify any inaccuracy in anticoagulant/antiplatelet and antibiotics. Findings of this audit will be reviewed in Quality Assurance Performance Improvement beginning in September for a period of 3 months.	

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F 641	Continued From page 15 was coded on the 7-day look-back period for receiving an anticoagulant medication but had instead received an antiplatelet medication, which was coded in error. The MDS Coordinator confirmed that Resident #96 was coded on the 7-day look-back period for receiving an anticoagulant medication and was receiving an antiplatelet medication instead. She confirmed Resident #96 was on Macrobid, an antibiotic, and was not coded for antibiotic during that 7-day look-back period. The MDS Coordinator confirmed these were coded incorrectly by a remote MDS worker.	F 641		
F 656 SS=E	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 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		10/7/24

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F 656	Continued From page 16 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 resident and staff interviews, record view, facility policy review, the facility failed to implement a care plan for nail care for Resident #41 and failed to develop a care plan for the application of leg braces for Resident #51 and failed to develop a behavior monitoring care plan for Resident #113 for three (3) of 26 resident care plans reviewed. Resident #41, #51 and #113 Findings include: Record review of facility policy titled, "Care Plans" dated October 2021, revealed, "Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument)	F 656	Resident # 41- On 8/27/24 the Director of Nurses (DNS) assessed resident's nails and assessed the resident and provided nail care in accordance with the care plan. Care plan was reviewed and updated as needed. Resident #51- on 8/29/24 the Minimum Data Set (MDS) nurse developed a care plan for the application of leg braces. Resident #113- On 9/1/24 MDS nurse developed a care plan for behavior monitoring to include binge eating.	

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F 656	Continued From page 17 manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change". Resident #41 Review of the "Care Plan" undated for Resident #41 revealed, "Self Care Deficit related to: decreased functional abilities, weakness". Also revealed, "Nail, hair, and oral care daily and as needed." On 8/26/2024 at 11:36 AM, an observation of Resident #41 revealed, fingernails on both hands were long and measured approximately one-half (1/2) inch in length. On 8/27/2024 at 10:58 AM, an interview with Licensed Practical Nurse (LPN) #5, confirmed Resident #41's nails were long and needed to be cut. An interview with the Minimum Data Set (MDS) Nurse on 8/29/2024 at 8:51 AM revealed, the purpose of the care plan was for staff to know how to take care of the resident. She confirmed the care plan for nail care was not followed for Resident #41. Review of the "Admission Record" revealed the facility admitted Resident #41 on 10/26/2023 with a medical diagnoses that included Type 2 Diabetes mellitus with diabetic neuropathy. Resident #51 Record review of Resident #51's care plan revealed no care plan was developed for leg	F 656	100% audit of residents with behaviors, splints and braces and those requiring assistance with nail care was completed on 9/3/24 by the DNS and MDS nurse.. No additional concerns were noted. All residents have the potential to be affected by this practice. Beginning 8/26/24 the DNS will assure that each resident receives nail care in accordance with the plan of care. If residents refuse care, a notation will be added to the progress notes along with a tendency to refuse care noted in the care plan. Beginning 8/27/24 the MDS nurse will assure that any resident with either a splint/brace or in need of a care plan for binge eating, will have a care plan developed timely. On 8/26/24, the DNS provided education to the MDS nurse regarding compliance with the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual related to development of care plans. On 8/26/24, the DNS provided education to the nursing department regarding implementation of nail care care plan with an emphasis for providing care and notification to the nurse of refusal of care. Beginning 8/29/24 the DNS and or unit managers will monitor 5 residents a week for 3 months to assure that nail care is	

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F 656	Continued From page 18 brace usage for the resident's range of motion needs. During an interview on 8/26/24 at 11:50 AM, Resident #51 stated he should be wearing leg braces two times a day to help the mobility in his legs, but the staff were not applying these. He stated he had recently completed therapy and they would pick him back up when his movement improved, but he needed the braces to help improve his limited range of motion. Interview with the Physical Therapist (PT) on 8/27/24 at 2:35 PM, revealed the resident's therapy was discontinued on 8/23/24 and the team met to discuss the plan for the resident to continue to use the braces two times a day for one to one and a half hours each time. He stated he was unaware that resident had not worn these since therapy stopped last week and the braces are needed to regain his functional mobility and to increase his potential to walk. An interview with the Minimum Data Set (MDS) Coordinator on 8/29/24 at 8:45 AM revealed she was responsible for the development of the care plans. She confirmed the care plan for Resident #51's brace use was not developed due to a failure in the communication process for nursing to enter orders from the therapy department. She confirmed the care plan's purpose was to provide information on the care needed for the residents and the facility failed to develop a care plan for this resident's leg brace use. During an interview with the Director of Nursing (DON) on 8/29/24 at 9:15 AM, she confirmed the facility failed to develop a care plan for the brace usage for Resident #51. She confirmed there	F 656	provided in accordance with the plan of care. Any variance to the plan of care will be addressed immediately. Beginning 8/29/24 Administrator/DNS will perform a weekly audit of 100% of MDSs submitted as completed to ensure all residents with splints/braces and/or binge eating have a corresponding care plan. Audit will continue weekly x4 weeks followed by review of 50% of submitted MDSs for an additional 2 months. Any discrepancies noted will be corrected immediately by the RNACs and addressed in Quality Assurance Performance Improvement monthly for 3 months beginning in September.	

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F 656	Continued From page 19	F 656		

was a failure in their communication system and after the Nurse Practitioner signed the order for these braces, it was not received by nursing staff to put into their system and the care plan was not developed.

An interview with the Administrator on 8/29/24 at 10:00 AM, revealed the facility failed to follow the process to enter the orders from therapy into their system for nursing service to follow, and a care plan was not developed. She confirmed the facility failed to ensure a care plan was developed for the resident's range of motion.

Record review of Resident #51's "Admission Record" revealed the facility admitted the resident on 2/23/22. Diagnoses included Paraplegia, Muscle wasting and Atrophy.

Record review of Resident #51's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/10/24, revealed a Brief Interview for Mental Status (BIMS) of 14 which indicated the resident was cognitively intact.

Resident # 113

Record review of the "Admission Record" revealed the facility admitted Resident # 113 on 7/19/24 with a diagnosis of Type 2 Diabetes with Hyperglycemia and Schizophrenia and was re-admitted on 8/14/24 with a diagnosis of Binge Eating Disorder.

Review of the care plans for Resident #113 revealed there was not a care plan developed related to the diagnosis of Binge Eating Disorder.

During a record review and interview with the

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F 656	Continued From page 20 Registered Nurse (RN) Director of Clinical services on 8/28/24 at 1:55 PM, she confirmed after reviewing the care plans for Resident #113 there was not a care plan developed related to Binge Eating. She stated the diagnosis must not have gotten picked up when she came back from the hospital on 8/14/24. In an interview with the Director of Nursing (DON) on 8/28/24 at 2:00 PM, she revealed after review of Resident # 113's care plans, there was no care plan developed related to the behavior of Binge Eating. In an interview with the RN/MDS Coordinator on 8/28/24 at 3:45 PM, she revealed the purpose of the care plan is to accurately reflect the specific needs of a resident and staff can properly provide care for the residents. Record review of Resident # 113's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/24, Section C revealed a Brief Interview for Mental Status (BIMS) score was 5, indicating the resident was severely cognitively impaired.	F 656		
F 677 SS=E	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 and staff interviews, and facility policy review, the facility failed to provide personal hygiene as evidenced	F 677	The nurse assessed resident #41 on 08/27/2024 and assured the nails were trimmed. No skin tears or injuries noted	10/7/24

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F 677	Continued From page 21 by failure to provide nail care for one (1) of 24 sampled residents. Resident #41 Findings Include: Review of the facility policy titled "ADL's" dated 8/2021 revealed "Policy: Ensure ADL's (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..." An observation and interview with Resident #41 on 8/26/2024 at 11:36 AM, revealed, she was sitting in her wheelchair in her room. She held up her hands and stated, "I need my nails cut. I keep scratching myself." The resident revealed her nails had not been cut in a long time and stated she was a diabetic. The nails on both hands were long and measured approximately one-half (1/2) inch in length. An interview with Licensed Practical Nurse (LPN) #5 on 8/27/2024 at 10:58 AM, confirmed Resident #41's nails were long. She revealed that nail care had to be completed by a nurse since the resident was a diabetic. LPN #5 explained that diabetic nail care was not scheduled for the nurses to perform, it was just something the nurses did when it was needed. She confirmed long nails could cause a skin injury for the resident. An interview with the Director of Nursing (DON) on 8/27/2024 at 11:26 AM, confirmed diabetic nail care should be completed as part of the daily personal hygiene care. She revealed they did not have nail care set up on the Treatment Administration Record (TAR) for the nurses to	F 677	from the deficient practice. Education was initiated on 8/27/24 by the Director of Nurses (DNS) and Director of Clinical Education (DCE) to the Certified Nurse Aides (C NA) regarding care of resident's rights specifically nail care and personal hygiene. The resident's care plan was reviewed and updated by the DNS on 8/27/24. All residents are potentially affected by this practice The DNS conducted a 100% audit on 8/28/24 of all residents to assess for jagged or long nails. Any residents identified with long/jagged nails immediately corrected. Any resident refusing nail care was care planned and charted as such. In-service was continued on ensuring nail care is provided. Going forward, systemic changes implemented on 8/28/24 to avoid this issue included implementing daily environmental rounds check list to include observation of nails. Environmental rounds will be completed daily. Any resident with log nails or jagged nails should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the Administrator (ADM) on 8/28/24 with team members regarding updated environmental rounds along with implementation. Education was initiated by the DCE on 8/27/24 regarding checking nails and	

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F 677	Continued From page 22 perform, but her expectations were for the nail care to be performed when it was needed. Review of the "Admission Record" revealed the facility admitted Resident #41 on 10/26/2023 with a medical diagnosis of Type 2 diabetes mellitus with diabetic neuropathy. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #41 is moderately cognitively impaired.	F 677	toileting as part of the C N A and nursing daily care of residents. On 08/27/2024 the Administrator began an audit of a minimum of 5 residents weekly for 4 weeks then monthly for an additional 2 months to assure that nails are trimmed and in accordance with the resident's wishes. This process improvement plan will be reviewed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI in September for a minimum of 3 months to assure continued compliance.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		10/7/24

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F 688	Continued From page 23 Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one (1) of three (3) residents reviewed for range of motion. Resident #51 Findings include: Record review of facility policy titled, "Splinting and Orthotics" dated 9/5/17, revealed, "It is the policy of (proper name of rehabilitation service) that therapist recommend, within their scope of practice, appropriate splinting and orthotics for patients currently receiving therapy services, as the need arises. For splinting/orthotic needs that the therapist deems outside their scope of practice or expertise, therapist will notify the facility and make appropriate referrals to outside sources .... Therapy personnel will work with the facility, patient and caregivers to recommend appropriate materials for fabrication/modification and/or to recommend prefabricated splinting/orthotic options. Once trained by therapy, the facility is responsible for ...implementing the wearing schedule to include donning/doffing (putting on/taking off) devices as recommended..." In an interview on 8/26/24 at 11:50 AM, Resident #51 stated he was supposed to be wearing leg braces two times a day to help improve the mobility in his legs, but the staff were not applying these. He stated he had recently completed therapy and they would pick him back up when his movement improved. He stated the braces are designed to gradually increase his ability to straighten his legs with his goal to eventually	F 688	Resident #51 was assessed by the Director of Nurses (DNS) on 8/27/24 with no negative impact noted. On 8/27/24, the DNS consulted therapy to verify recommendations for the devices to include when to apply and remove. Orders were transcribed as ordered followed with updating the resident's care plan. All residents with braces/splints have the potential to be affected by this practice. On 8/27/24 DNS and Director of Rehab (DOR) audited 100% of all residents with braces/splints to determine if any other resident might be affected. No other opportunity was noted. On 8/28/24 the Reginal Director of Operations (RDCO) for therapy provided an in-service for all therapy team members to ensure that anyone discharged from therapy is referred to restorative nursing. On 08/28/24 the DNS/ Director of Clinical Education educated nursing team members related to application of braces and splints in accordance with the physician's orders. Going forward, when a resident with splits/braces is discharged from therapy, the interdisciplinary team (IDT) will review the plan and assure orders specific, and communication occurs with the nursing team to assure continuity of care with the application of splits/braces.	

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F 688	Continued From page 24 walk. He expressed his concern that he had told the staff that he needed his braces, but they had not applied since he completed therapy last week. Braces were observed to be in a box against the wall in the resident's room. Observations and interviews with the resident on 8/26/24 at 1:50 PM, 8/27/24 at 8:30 AM, 8/27/24 at 10:30 AM, and 8/27/24 at 2:20 PM revealed the braces were noted to be in the box in the same position as previously observed. Each interview of the resident revealed the staff had not applied the braces. During an interview with the Physical Therapist on 8/27/24 at 2:35 PM, revealed the resident's therapy was discontinued on 8/23/24 and the team met prior to discharge to discuss the plan for the resident to continue to use the braces two times a day for one to one and a half hours each time. He acknowledged the time frame for the braces to be used was decided on based on the resident's preference for his daily activity choices since he was required to be in bed while wearing. He stated he was unaware that resident had not worn these since therapy stopped last week and the braces are needed to regain his functional mobility and to increase his potential to walk. Interview with the Director of Nursing (DON) on 8/27/24 at 3:00 PM revealed she was unaware of the concern with the braces. She stated she did not see an active order for the use of the braces and the resident was not one to refuse care. Interview with the DON at 3:40 PM on 08/27/24 she acknowledged she spoke with therapy and it appears the facility failed to put an order into the system when the resident was discontinued from	F 688	Beginning, 8/29/24 Audits of 100% therapy discharges will be conducted by the Administrator or DOR to ensure all discharges with splints/braces are referred to restorative nursing and that they are being applied in accordance with the plan of care weekly x 4 weeks and 50% of discharges monthly for an additional 2 months. Any variance will be addressed immediately. Results of the audits will be addressed in Quality Assurance Performance Improvement for a minimum of 3 months beginning in September.	

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F 688	Continued From page 25	F 688		

therapy. She stated therapy had a plan of care and had in-serviced several nursing staff members on the splint use, but the staff failed to follow through and put the order in, therefore no tasks were entered for the staff to follow. She confirmed the facility failed to provide the resident with range of motion services to increase his mobility.

An interview with Certified Nursing Assistant (CNA) #6 on 8/28/24 at 9:00 AM, revealed she worked with Resident #51 and had been trained on the use of the braces, but he had refused to put these on. She stated she worked 6 AM until 2 PM and when she came to work in the morning, she would attempt to put these on him and he declined. She reported this to the night shift nurse, but she did not report to the day shift nurse or go back to the resident later during her shift. She stated she was unaware that the reason to follow the time frame requirement was for the resident's preference for his day to day activities.

During an interview on 8/28/24 at 9:45 AM, the Physical Therapy Assistant (PTA) revealed the facility staff failed to put the braces on the resident as required. She stated therapy and the resident worked out a schedule from 7:30 AM - 9:00 AM so he would be able to go to smoke break at 9:00 AM. He had to be lying in bed for the braces to be on, and he did not want to miss his smoke break. She stated he was being asked to put the braces on at 6:00 AM and he did not want these on at that time after it was agreed upon with therapy to have on at 7:30 AM. She stated he had been in therapy until last week and therapy had been ensuring the braces were used as ordered. She stated since his therapy was discontinued, they were unaware the staff

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members were not applying the braces. She stated the goal of these braces was for the resident to regain functional mobility to be able to meet his goal to stand and walk and this would offer him the chance to meet that goal as his range of motion improved.

During an interview on 8/28/24 at 9:50 AM, Resident #51 stated, "Thank you for getting' this done for me. I might not ever walk again, but this gives me a chance to be able to." He stated he was hopeful the system they now have in place would work so this would not happen again. He acknowledged the time frame that had been agreed upon would allow him to go outside to smoke. He stated he had to be in bed while he was wearing the braces, but that was not a problem as long as he could go to his smoke breaks. He then stated, "Thank you very much!" Resident observed lying in bed with braces on both legs.

During an interview with the DON on 8/29/24 at 9:15 AM, she confirmed that after the Nurse Practitioner signed the order for these braces, it was not received by nursing staff to put into their system.

An interview with the Administrator on 8/29/24 at 10:00 AM, revealed the facility failed to enter the orders from therapy into their system for nursing service to follow.

Record review of "Prescription-Standard Written Order" dated 6/11/2024 revealed " ...Positional orthosis, Rigid Support right ...and left ...Medical Necessity: Pt (patient) is contractured, improves ROM (range of motion) ..."

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F 688	Continued From page 27 Record review of "In-service Training Report" dated 7/2/24 with therapy training four nursing staff members on the knee brace/orthotics. Recommendation/approaches listed as "Patient will wear knee braces and ...orthotics twice daily (one time in morning and one time in afternoon) up to patient's tolerance with understanding that patient will doff orthotics. Preferably wear from 7:30 - 9:00 AM and 1:30 - 3:00 PM to improve patient's wearing tolerance to in turn improve patient's functional mobility tasks." This was signed by four nursing service staff members. Record review of Resident #51's "Admission Record" revealed the facility admitted the resident on 2/23/22 with diagnoses that included Paraplegia, Muscle wasting and Atrophy. Record review of Resident #51's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/10/24, revealed a Brief Interview for Mental Status (BIMS) of 14 which indicated the resident was cognitively intact.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		10/7/24

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F 692	Continued From page 28 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to address dietary recommendations to change and/or increase a peg (percutaneous gastrostomy) tube feedings and water flushes to meet the nutritional needs for one (1) of three (3) residents reviewed who received enteral nutrition. (Resident #112) Findings include: A review of the policy titled "Queuing RD (Registered Dietician) Recommendations & Follow-up," with an effective date of 7/1/21 revealed " ...Recommendations for changes to enteral feedings, enteral flush orders ... is reviewed to ensure that the supervising physician is in agreement with nutrition therapy orders. The order is then signed, acknowledged and activated in the electronic medical record by a licensed nurse..." Record review of a "Progress Note" for Resident #112 by the RD dated 8/5/24 at 9:57 AM, revealed: Note Text: Consult for tube feeding (TF) caloric intake: CBW (Current body weight) 148.9. ... EEN (exclusive enteral nutrition) 1692-2030 kcal	F 692	Resident # 112-as of 8/9/24, this resident no longer resides in the center. 100% audit of all dietary recommendations completed by the Director of Nurses (DNS) on 8/29/24 with no additional deficient practice. On 8/29/24 the Director of Nurses (DNS) completed an audit of 100% of all dietary recommendations for residents receiving enteral feedings to assure they have all been addressed by the physician, transcribed in accordance with orders, and implemented. All residents on enteral feedings have the potential to be affected by this practice. Beginning 8/29/24 the Registered Dietician (RD) will begin queuing dietary recommendations for enteral orders into the electronic health record. The nurse will review the newly cued orders and notify the Medical Doctor or Nurse Practitioner (NP) for confirmation and implementation. The order will be reviewed in the clinical meeting with the	

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F 692	Continued From page 29 (kilocalorie). ...Glucerna 1.2 237 cc (cubic centimeters) bolus with 200 ml (milliliters) water flushes provides 948 cc formula, 1127 kcal. ... Concerned that current orders are inadequate to meet the nutritional needs. Recommend: 1.) Discontinue current TF/flush order. 2.) Start Glucerna 1.5 237 cc bolus five times a day with 100 cc flush before and after each bolus to provide 1185 cc formula, 1780 kcal, 100 grams protein, 900 cc plus medication flush 900 cc free water plus 1000 cc flush. Record review of the "Order Summary Report" with active orders as of 8/9/24 revealed a physician's orders dated 8/02/24 "Enteral Feed Order every 6 hours Glucerna 1.2 calorie (237 ml) bolus via peg tube with 200 ml water flushes." An interview with the Director of Nursing (DON) on 8/29/24 at 8:00 AM revealed she was not notified of the RD's recommendations until 8/9/24 and the resident was no longer in the facility. A phone interview with the RD on 8/29/24 at 8:35 AM, she revealed after review of her records she assessed Resident #112 on the morning of 8/5/24 and sent the recommendation to the interdisciplinary team email group the same morning at 10:12 AM. A review of the email sent by the RD revealed the email to the Interdisciplinary team was documented as sent on 8/5/24 at 10:12 AM with recommendation for Resident #112. A follow-up interview with the DON on 8/29/24 at 9:00 AM, revealed after review of the emails sent from the RD with the that she failed to see the recommendation for Resident #112 in the email	F 692	interdisciplinary team to assure changes have been communicated to the team. On 8/29/24 the DNS provided education for licensed nurses and the Registered Dietitian related to submission of dietary recommendations with a focus on transcription and implementation. Beginning 8/29/24 the Administrator/DNS/Assistant Director of Nurses will audit all dietary recommendations received to assure they have been transcribed correctly, submitted to the physician and implemented in accordance with physician/NP orders. This audit will occur weekly x 4 weeks and monthly x 2 months. Any missed recommendations will be corrected immediately by the DNS and addressed in Quality Assurance and Performance Improvement (QAPI) each month beginning in September	

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F 692	Continued From page 30 on 8/5/24. She stated that she normally gets the dietary recommendations for tube feeders, obtains approval from the provider and writes the orders. She stated Licensed Practical Nurse (LPN) #1 also takes care of those recommendations. The DON then stated the provider should have been notified and the orders to change and increase tube feedings/flushes should have been written and carried out. An interview with LPN #1 on 8/29/24 at 9:15 AM, she confirmed she did get the email on 8/5/24 from the RD with the recommendations for Resident #112. She then stated that she only takes care of the dietary recommendations if the DON asks her to and confirmed the DON did not ask her to take care of Resident #112's RD recommendations. Review of the "Admission Record" revealed the facility admitted Resident #112 on 8/2/24 with diagnoses that included Cerebral Infarction and Encounter for attention gastrostomy.	F 692		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced	F 742		10/7/24

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by:
Based on staff interview, record review and facility behavior monitoring document review, the facility failed to ensure a resident with a new diagnosis of Binge Eating Disorder received appropriate behavioral monitoring and interventions to address the disorder for (1) one of (3) residents reviewed with behaviors. (Resident #113)

Findings include:

Review of a statement on facility letter head titled," Behavior Monitoring" undated, revealed "Specific behaviors are identified based on resident assessments. Behaviors are monitored by the nurses and quantitatively recorded in the medical record."

Record review of the "Admission Record" revealed the facility admitted Resident # 113 on 7/19/24 with a diagnoses that included Type 2 Diabetes with Hyperglycemia and Schizophrenia. Resident #113 was re-admitted on 8/14/24 with a new diagnosis of Binge Eating Disorder.

In an interview with Certified Nurse Assistant (CNA) #2 on 8/27/24 at 2:00 PM, she revealed that Resident #113 was always wanting and looking for snacks and has been known to take food off the food carts. She stated that she was aware the resident was a diabetic and only gave her low sugar snacks when she wanted them. CNA #2 confirmed she was unaware of the diagnosis of Binge Eating Disorder.

In an interview with Registered Nurse (RN) #2 on 8/28/24 at 8:00 AM, she revealed that Resident #113 was always hungry and asked for snacks

Upon return to the center on 9/1/24 for hospitalization for uncontrolled diabetes, the Director of Nurses (DNS) assessed resident #113 and determined no negative effects of lacking behavior monitoring A care plan was developed for behaviors and a monitoring order placed for behavior monitoring specific to binge eating. Education was provided to the Minimum Data Set Nurse, Social Services and nursing by the Director of Nurses on 8/27/24 regarding the need to complete care plans and monitoring tools on admission for any resident admitted with a psychiatric diagnosis.

On 8/28/24, the DNS conducted and audit of 100% of residents with a psychiatric diagnosis to assure each resident had behavioral monitoring and interventions in place to address the disorder.

Any resident has the potential to be affected by this practice.

On 8/28/24 the systemic approaches to avoid this practice from occurring again included reviewing the diagnosis and clinical health status of any new or readmitted resident to identify those residents with a current psychiatric diagnosis.

On 8/28/24 the Interdisciplinary Team (IDT) began reviewing new or readmitted residents in a clinical meeting to identify specific behaviors associated with each individual resident's needs. The IDT will

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F 742	Continued From page 32 and has been known to walk up to a tray cart and take food from the cart. In an interview with CNA #3 on 8/28/24 at 10:30 AM, she revealed she was unaware that Resident #113 had a Binge Eating Disorder. She then revealed the resident would take food from the desk or food cart and was always asking for more. Record review of the Medication Administration Record revealed an order dated 8/14/2024 "Document number of episodes per shift of target behavior: 1. Hallucinations 2. Delusions 3. Paranoia 4. Aggressiveness 5. None ..." There was no monitoring for the Behavior of Binge Eating Disorder. During a record review and interview with Director of Clinical Services on 8/28/24 at 1:55 PM, she revealed after review of the Medication Administration Record for Resident #113, she was unable to find monitoring related to Binge Eating behavior. She stated the diagnosis must not have gotten picked up when she came back from the hospital on 8/14/24. In an interview and record review on 8/28/24 at 2:00 PM, the Director of Nursing (DON) revealed after review of the Medication Administration Record for Resident #113 that there was no behavior monitoring in place for the Binge Eating Disorder diagnosis. She revealed she received that diagnosis when she returned from the hospital on 8/14/24. The DON confirmed Resident #113 should have been monitored for that behavior. She revealed the purpose of behavior monitoring is timely management of the behaviors. The DON then revealed that her binge	F 742	identify specific interventions to address disorders, such as binge eating. The interdisciplinary team was educated on 8/27/24 by the Administrator and DNS regarding identification of a psychiatric diagnosis along with specific behaviors and the need for monitoring and interventions. To assure continued compliance, beginning 9/1/24 the Administrator will assure an audit is completed weekly times (x) 4 weeks and then monthly x 2 of new and readmitted residents to assure specific behaviors are being identified and addressed with appropriate interventions. Any negative variance will be addressed immediately. This process improvement plan will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI in September to assure continued compliance.	

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F 742	Continued From page 33 eating could lead to elevated blood sugars. Record review of Resident # 113's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/24, Section C revealed a Brief Interview for Mental Status (BIMS) score was 5 indicating the resident was severely cognitively impaired.	F 742		
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 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:	F 761		10/7/24

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F 761	Continued From page 34 Based on observation, resident and staff interviews, record review, and facility medication checklist review, the facility failed to store an inhalant medication in a locked storage compartment as evidenced by medication being left at the resident's bedside for one (1) of seven (7) medication observations. Resident #21 Findings include: Record review of "Performance Checklist Skill 21-1 Administering Oral Medications", dated 2014, revealed, " ... Implementation ... l. Returned stock containers or unused medication to shelf or drawer, labeled cups and poured medications before leaving preparation area, did not leave drugs unattended. ...2. Administered medications ... p. Stayed until patient/resident completely took all medication by the prescribed route..." Record review of facility's letterhead, undated, revealed, "(Proper name of facility) uses the Medication Administration Competency Checklist from Perry and Potter as a guideline for medication administration". During an interview with Resident #21 and an observation in resident's room on 8/26/24 at 10:50 AM, it was revealed that a respiratory inhaler Aerosol Solution device, was on resident's overbed table. The resident stated the nurse brought it in for him to use earlier and she left it at his bedside when she left the room. On 8/26/24 at 10:55 AM, an interview with Licensed Practical Nurse (LPN) #6 revealed she took the inhaler in Resident #21's room for him to use and after it was administered, she forgot to put it back into the locked medication cart. She	F 761	The inhaler was removed from the room immediately. Resident #21 was assessed by the Director of Nursing (DNS) on 8/26/24. There were no negative findings for this resident including no evidence that he had taken additional puffs. The nurse was provided one on one education by the Director of Clinical Education (DCE) on 8/26/24. All residents at the center are at risk of this practice. On 8/26/24 The DNS/ Assistant Director of Nursing (ADNS) completed an audit of 100% of the resident rooms to assure that no other resident had medications at the bedside. No additional medications were found. On 8/26/24, the DNS/ADNS/DCE initiated an in-service for the nursing staff regarding proper storage of medications with an emphasis on securing inhalants in a locked area. DNS/ADNS/DCE will perform audits of licensed nurses performing medication administration, not limited to medication storage after administration for 5 times (x) weekly x 4 weeks then weekly for two months to assure medication administration is performed in accordance of medication administration guidelines beginning 8/28/24. . This process improvement plan will be reviewed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI in September to assure continued compliance.	

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F 761	Continued From page 35	F 761		

stated she had been in-serviced on medication administration and was aware that medications should not be left at a resident's bedside and should be placed in the locked medication cart.

During an interview on 8/26/24 at 11:35 AM, the Director of Nursing stated Resident #21 was assessed for medication administration with supervision, not independent medication administration. She stated a medication not being stored properly posed a risk for another individual to obtain the medication. She confirmed the facility failed to secure a medication in a locked cart.

Record review of "Order Summary Report" with active orders as of 8/28/24 revealed an order dated 8/9/24 for "Spiriva Respimat Inhalation Aerosol Solution ... two inhalations inhale orally one time a day related to Chronic obstructive pulmonary disease.

Record review of the Electronic Medication Administration record (eMAR) revealed on 8/26/24, the morning dose of Spiriva Inhaler was signed by LPN #6 as administered to Resident #21.

Record review of Resident #21's "Self-Administration of Medications", dated 5/15/23, revealed, "Medications, 1a. Storage - with staff." This evaluation also revealed, "7. Physician Order ... b. Resident may self-administer medications with supervision ... date of order 11/15/22".

Record review of Resident #21's "Admission Record" revealed the facility admitted the resident on 7/12/2017. Diagnoses included Chronic

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F 761	Continued From page 36 Obstructive Pulmonary Disease and Asthma. Record review of Resident #21's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review the facility failed to ensure foods were palatable, attractive and at a safe and appetizing temperature, for seven (7) of 12 residents sampled for dining. Resident #19, #41, #52, #88, #101, #102, and #108. Findings include: Review of the facility policy titled "Food: Quality and Palatability" with a revision date of 9/2017 revealed "Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are	F 804	Residents # 19, # 41, # 52, #88, #101, # 102 and # 108 were each assessed by the nurse 8/29/24 No negative outcomes were identified as a result of this practice. All residents will be interviewed by 9/27/24 by the Dietary Department to identify other residents that might be affected by this practice. The Dietary manager will assure that Scaled Recipes will be utilized to ensure consistent quality, and quantity production by 9/13/24. Production Sheets to be reviewed by the dietary manager prior to production to	10/7/24

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F 804	Continued From page 37 prepared and served in a manner, form, and texture to meet resident's needs..." Resident #19 During the resident council meeting on 8/27/24 at 3:05 PM, Resident #19 revealed the cornbread was so flat and hard there was no way to chew and swallow it. Resident #19 confirmed he had received foods that were not cooked thoroughly before. Review of the "Admission Record" revealed the facility admitted Resident #19 on 12/23/2023 with a medical diagnosis of Mixed conductive and Sensorineural hearing loss. Review of the MDS with an ARD of 7/30/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #19 is cognitively intact. Resident #41 An interview with Resident #41 on 8/26/2024 at 12:15 PM, revealed the facility did not fix the things she liked to eat. She explained that she liked rice with gravy, but they never added the gravy. She revealed she had spoken with the Dietary Manager, but the gravy continued to be an issue. Resident #41 stated the food tasted bad and had no flavor and she could not eat the food on most days. An observation and interview with Resident #41 during a lunch meal on 8/27/2024 at 12:10 PM, revealed the meal consisted of mashed potatoes, diced potatoes, a hamburger patty with Barbeque sauce on a bun. The resident revealed she did	F 804	ensure appropriate quality and quantity is prepared by 9/13/24. Food Temperatures to be checked before each meal service and documented on a temperature recording log-Trayline Checklist 3 times (x) daily, 7 days per week, x on-going by the dietary manager beginning 9/13/24. The dietary department will interview each resident for preferences by 9/27/24 and entered into Mealtracker. Obtaining Resident Preferences is to ensure their likes and dislikes are being honored and the Residents are receiving foods they prefer and enjoy. By week of 9/13/24, a Resident Food Committee will be initiated meeting 1 day per week for 30 days: Bi-weekly for 60 days, then 1x monthly moving forward. Food Committee notes to be completed and tracked through HCSG Tourweb system for documentation tracking. The Dining Service Director is to document all Resident concerns and follow up on each concern within 48 Hours of the received date. Beginning 9/10/2024, Administrator or DNS will receive Test Tray 5 days per week, 2x daily, for 30 days: 5 days per week, 1x daily, for 60 days beginning 9/10/24. Beginning the week of 9/13/24, the Administrator or DNS will audit food committee notes to ensure all grievances are resolved. 100% of grievances x 4 weeks then 50% monthly x 2 additional	

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not think she needed two different potatoes and the bun due to being a diabetic.

Review of the "Admission Record" revealed the facility admitted Resident #41 on 10/26/2023 with a medical diagnosis of Type 2 diabetes mellitus with diabetic neuropathy.

Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #41 is moderately cognitively impaired.

Resident #52

An interview with Resident #52 on 8/26/2024 at 1:38 PM revealed the food tasted bad. He stated he could ask for something else, but you probably couldn't eat it either. He explained that he got a hamburger every night because what they cooked at night was "awful." The resident confirmed he had told the Dietary Manager, and he had told staff in resident council meeting and revealed nothing ever gets done.

Review of the "Admission Record" revealed the facility admitted Resident #52 on 9/23/2022 with medical diagnoses that included Bipolar disorder.

Review of the Quarterly MDS with an ARD of 7/18/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #52 is cognitively intact.

Resident #101

An interview with Resident #101 on 8/27/2024 at

months. This issue will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI in September to assure continued compliance. Any variance will be addressed immediately.

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8:41 AM, revealed the food "tasted terrible" and was cold. He explained the food was not cooked right and the chicken was not cooked thoroughly. He stated, "It looks like they just throw some things together to make a meal." The resident stated they need more options for food and revealed the only thing they can get besides the main meal was a hamburger or chicken sandwich.

An observation of Resident #101 lunch meal on 8/28/2024 at 12:15 PM, revealed the resident sent his tray back with the aide to be warmed up in the microwave due to being cold. Resident #101 received 2 hamburgers on buns, diced potatoes and a blueberry muffin.

Review of the "Admission Record" revealed the facility admitted Resident #101 on 8/6/2024 with a medical diagnosis of Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema

Review of the Quarterly MDS with an ARD of 8/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #101 is cognitively intact.

Resident #102

An observation and interview on 8/26/24 at 11:50 AM, revealed Resident #102 sitting up on the side of her bed eating her lunch which consisted of a ham pasta, creamed spinach, bread, fruit cup, and water. Observed to only eaten a small amount of lunch at that time. She stated she did not like the food and even though there are alternate items, she often does not order these in time to receive. She stated the food is bland and

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F 804	Continued From page 40	F 804		

not seasoned and "it's just not good" and she kept snacks available so she would have something to eat. She stated she had talked to the Dietary Manager about her likes and dislikes, but even if an item is on her likes list, it still does not taste good.

An observation and interview on 8/27/24 at 11:40 AM, revealed Resident #102 sitting up on side of her bed eating her lunch which consisted of a chunky chicken salad sandwich (which she had eaten approximately 95% of), cubes potatoes that were not browned (appeared to be the full serving still on plate), cole slaw (full cup remained), chocolate chip cookie, and water. Meal ticket revealed a tuna salad sandwich was served which was incorrect. She stated the food was not good. Resident #102 stated the potatoes were not tender or fully cooked and the cole slaw tasted ruined or was leftover and too much mayonnaise was added.

During an interview on 8/27/24 at 2:50 PM, the Dietary Manager revealed both tuna and chicken salad were served for lunch so the wrong item was served. The Dietary Manager stated she had talked to the resident about her preferences and likes and dislikes and options she would like to use as substitute items. She confirmed there had been concerns about the food expressed to her by this resident and other residents.

A sample tray was received from the kitchen on 8/27/24 at 11:35 AM. The food consisted of a barbeque hamburger patty on a bun, diced (hash brown cube like) potatoes, salad with lettuce and a slice of tomato, cole slaw, cookie, tea. Hamburger patty sampled and was not warm and the flavor was bland. The cole slaw was sampled

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by State Agency and noted too much mayonnaise was in the cole slaw. The flavor tasted like eating mayonnaise from the jar. The potatoes were not warm and were not browned on the outside or tender on the inside.

Record review of Resident #102's "Admission Record" revealed the facility admitted the resident initially on 12/5/23 with the most recent admission date of 3/28/24. Diagnoses included Type 2 Diabetes Mellitus and Gastro-esophageal reflux disease.

Record review of Resident #102's MDS with and ARD of 7/3/24, revealed a BIMS score of 15 which indicated the resident was cognitively intact.

Resident #108

During the resident council meeting on 8/27/24 at 3:05 PM, Resident # 108 revealed the residents do not have food choices. She explained they had a set menu, and they can only get what was on the menu or two alternates to choose from every day, which is either a hamburger or a chicken sandwich. She stated, "I'm a vegetarian and so is my roommate, and they don't have options for us." She revealed the food was disgusting and had no seasoning or flavor. Furthermore, she explained that she had been served lunch before and the next day was served the exact same thing for lunch and supper. She revealed the food was always cold and stated the vegetables were watery and ran together with other foods on the plate. Resident#108 stated the food was as though they just threw something together and occasionally the foods were not cooked thoroughly.

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F 804	Continued From page 42 Review of the "Admission Record" revealed the facility admitted Resident #108 on 6/6/2024 with a medical diagnosis of type 2 diabetes mellitus with diabetic neuropathy. Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.	F 804		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and snack program document review, the facility failed to provide residents with a bedtime snack for six (6)	F 809	On 08/27/24 the nurse assessed residents # 3, # 13, # 19, #88, # 94 and # 108 and no negative impact was noted	10/7/24

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F 809	Continued From page 43 of six (6) residents interviewed during the resident council meeting. Resident #3, #13, #19, #88, #94, and #108 Findings Include: Review of the "H.S. (Bedtime) Basic Snack Program: Evening" undated, revealed, "Basic snack program items delivered between 7:30 pm -8:00 pm. Bulk snack cart should include (2-3) basic choices for the residents." A resident council meeting was held on 8/27/2024 at 3:05 PM, in which Resident #3, #13, #19, #88, #94, and #108 revealed they were not receiving a bedtime snack. Resident #88 revealed the kitchen did bring snacks out at night, but they left them at the desk and they were not passed out to the residents. He revealed the residents that were able to go to the desk had been getting their snacks. He stated, "So it's first come, first served." He revealed if a resident was not mobile, they would not get a snack because they do not bring them to the rooms. Residents #3, #88, and #108 confirmed they were diabetics and all other residents in attendance agreed they would like a bedtime snack. An interview with the Administrator (ADM) on 8/27/2024 at 4:10 PM, revealed she was not aware that the residents were not getting a bedtime snack. She explained, that the kitchen was sending out individual snacks to the floor with a resident's name, but they had stopped doing that. She confirmed the diabetics needed a bedtime snack to ensure they did not experience low blood sugar. An interview with the Dietary Manager on 8/28/24	F 809	related to this practice. The residents each informed by the DNS that a snack wound be made available in the evening. Each resident's care plan was reviewed and updated accordingly. All residents who are able to receive foods orally have the potential for being affected by this practice. As of 9/13/24, the dietary service director will coordinate with the residents, administrator and the director of nursing to establish snack times that is comparable with the normal times in the community. As of 9/13/24, the dining service director will coordinate the preparation and delivery of snacks for residents. The dining services director will coordinate to assure that all residents preference interviews will be completed by 9/27/24. Beginning week of 9/13/24 a resident food committee will be held 1 day per week for 30 days: Bi-weekly for 60 days, then 1 time per monthly moving forward. A member of the nursing team will offer snacks to residents each night. On 9/9/24 the DNS initiated education to the nursing team regarding the snack policy and the need to offer and a snack available to each resident.	

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F 809	Continued From page 44 at 2:06 PM, revealed the kitchen did send out bulk bedtime snacks to the nurse's desk where the residents could grab and go, and the aides were responsible for passing them out. An interview with Registered Nurse (RN) #2 on 8/29/24 at 8:41 AM, revealed she worked 7 PM to 7 AM shift. She stated the kitchen brings the bedtime snacks to the nurse's station and most of the time the residents will come to the desk and ask for a snack. Resident #3 Review of the "Admission Record" revealed the facility admitted Resident #3 on 5/28/24 with diagnoses that included Type 2 diabetes mellitus without complications. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/6/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #3 is moderately cognitively impaired. Resident #13 Review of the "Admission Record" revealed the facility admitted Resident #13 on 5/29/2021 with diagnoses that included Type 2 diabetes mellitus with diabetic chronic kidney disease. Review of the MDS with an ARD of 6/19/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #13 is moderately cognitively impaired. Resident #19	F 809	A resident council meeting was held on 09/17/24 to inform residents that a snack will be made available for residents at hours of sleep. Beginning 9/13/24 the ADM will initiate audits of 5 residents per week for 4 weeks to assure they are offered and receive snacks at hours of sleep. Followed with audits of 10 residents per month for an additional 2 months to confirm that snacks are offered and provided. Any variance will be addressed immediately. The results of the audits will be addressed in Quality Assurance Performance Improvement (QAPI) as a performance improvement project in September and then monthly for a total of 3 consecutive meetings.	

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F 809	Continued From page 45	F 809		

Review of the "Admission Record" revealed the facility admitted Resident #19 on 12/23/2023 with diagnoses that included Mixed conductive and sensorineural hearing loss.

Review of the MDS with an ARD of 7/30/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #19 is cognitively intact.

Resident #88

Review of the "Admission Record" revealed the facility admitted Resident #88 on 2/9/2023 with diagnoses that included Type 2 diabetes mellitus without complications.

Review of the MDS with an ARD of 7/18/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #88 is cognitively intact.

Resident #94

Review of the "Admission Record" revealed the facility admitted Resident #94 on 9/29/2023 with a medical diagnosis of Unspecified dementia.

Review of the MDS with an ARD of 6/6/2024 revealed under section C, a BIMS summary score of 14, which indicates Resident #94 is cognitively intact.

Resident #108

Review of the "Admission Record" revealed the facility admitted Resident #108 on 6/6/2024 with diagnoses that included Type 2 diabetes mellitus

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 809	Continued From page 46 with diabetic neuropathy. Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.	F 809		