STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. BUILDING _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TYLERTOWN	200 MEDICAL CIRCLE TYLERTOWN, MS 39667

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with a Complaint Investigation (CI MS #25630) at the facility from 9/3/24 through 9/5/24. The SA investigated CI MS #25630 for misappropriation of resident's trust funds. The citations related to the complaint investigation was F602. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F690, F693 and F880. The facility had a census of 49 and was licensed for 60 beds.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		10/18/24

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

Electronically Signed | 09/26/2024

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F 690	Continued From page 1 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review the facility failed to provide perineal care in a manner to prevent the possibility of urinary tract infection for one (1) of four (4) residents reviewed for incontinent care. (Resident #5) Findings include: On 09/04/24 at 3:03 PM, during an observation of Certified Nurse Aide (CNA) #1 as she provided perineal care for Resident #5, the CNA assisted the resident to turn on her side to complete her perineal care. The CNA wiped the resident from the back to front, instead of front to back, a total of five (5) times. On 09/05/24 at 9:36 AM, in an interview with CNA #1, she stated she did not do the perineal care on the buttocks correctly. She stated she wiped back to front. She stated she should have wiped front to back. She stated her actions could cause the resident to develop a urinary tract infection (UTI).	F 690	Resident #5 was provided with proper incontinent care as directed by plan of care on September 05, 2024 by Certified Nurse Aide (CNA) #1 with competency evaluation completed per Director of Nursing Services (DNS). All current and new residents with bowel and/or bladder incontinence have the potential to be affected by the deficient practice. Education was initiated with CNAs on September 05, 2024 by the DNS and Assistant Director of Nursing Services (ADNS) regarding proper procedures for incontinent care. On September 10, 2024, the DNS and ADNS initiated evaluation of competencies with all active CNAs including full-time, part-time, and as needed (PRN) to ensure proper incontinence care is provided. Any CNA that has not completed their competency	

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F 690	Continued From page 2 She stated she has been a CNA for 17 years and has had training on perineal care. On 09/05/24 at 9:45 AM, in an interview, the Director of Nursing (DON) stated CNA #1 should have wiped front to back when she provided perineal care. She stated the CNA's actions could increase the risk of infection. Review of Admission Record for Resident #5 revealed the facility admitted the resident on 12/13/21. The resident's diagnoses included Chronic Kidney Disease and Dementia. Review of the Quarterly Minimum Data Set (MDS), for Resident #5, with an Assessment Reference Date (ARD) of 6/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident had severe cognitive impairment. Section GG revealed the resident required substantial/maximal assistance with toileting hygiene.	F 690	evaluation prior to September 18, 2024 will complete competency prior to working on the floor. Any newly hired CNA will be deemed competent in incontinent care prior to providing patient care. To ensure sustainability of the facility's corrective action, the Director of Nursing Services, Assistant Director of Nursing Services, or Unit Manager, beginning on September 19, 2024, will observe incontinence care for five residents per week for two weeks, then three residents per week for four weeks to ensure proper incontinence care is provided. Findings of these observations will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months, beginning October 17, 2024.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		10/18/24

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F 693	Continued From page 3 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews and facility policy reviews the facility failed ensure tube feedings were administered as ordered for one (1) of seven (7) residents who recieve enteral feedings. (Resident #1) Findings include: Review of the facility policy titled, "Enteral Nutrition," dated 8/1/12 revealed, "It is the policy of this facility to ensure that a nutritional assessment is completed for all residents receiving enteral feeding. Orders will reflect specific content to assure quality of enteral delivery ...2.The tube feeding order will be recorded. The following information should be included in the diet order or "comments" section: ... e. amount (c.c.s) of formula to be given for each feeding and total c.c.s to be given per 24 hours ..." On 9/3/24 at 10:48 AM, an observation revealed Resident #1 lying in bed with his PEG (Percutaneous Endoscopic Gastrostomy) tube feeding formula attached to an electronic pump. Jevity 1.5 was infusing per pump at the rate of 70 ml/hr. (milliliters/ per hour).	F 693	The Director of Nursing Services (DNS) corrected the deficient practice as it relates to Resident #1 on September 03, 2024 by verifying and re-entering the order to include the rate and type of feeding to be administered, and confirming that the tube feeding was infusing with Jevity 1.5 at 75mL/hr as ordered. Assessment of Resident #1 by DNS on September 03, 2024 revealed that resident had not suffered any weight loss or negative outcome as a result of the finding. All residents receiving tube feeding have the potential to be affected by the deficient practice. On September 03, 2024, the Assistant Director of Nursing Services (ADNS) performed an audit of all residents receiving tube feeding to ensure that the feeding was running with the correct rate and type of feeding as ordered. All other residents were identified to have the appropriate orders with the correct rate and type of feeding infusing. Licensed staff members were educated on	

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F 693	Continued From page 4 On 9/3/24 at 2:19 PM, in an attempt to verify the physician orders regarding the infusion rate of Resident #1's tube feeding in the resident's electronic chart, the orders were not available. There were orders regarding the flushing and care of the PEG tube, but no order available for review for the rate and type of feeding the resident was to receive. On 9/3/24 at 2:23 PM, in an interview with the Director of Nurses (DON), she was unable to locate the order when asked for a printed copy of the tube feeding orders for Resident #1. At that time, the DON stated that there had recently been an electronic update to their charting system and that she would check the MAR (Medication Administration Record). On 9/3/24 at 2:37 PM, the DON reported that within the electronic system, there were no current active orders for Resident #1's tube feeding rate or type of feeding to be administered. During an observation, interview and record review at 2:57 PM on 9/3/24, the DON provided an updated print out of Resident #1's "Order Summary Report, with active orders as of 8/14/24, in which the order had been corrected to include the resident's tube feeding order that included the type and rate of feeding the resident had been receiving since the initial order written on 1/25/16. The DON observed and confirmed the tube feeding was now infusing with Jevity 1.5 @ 75 ml/hr. as ordered. Further review of the order revealed that the physician's order included a time frame for the infusion in which the resident was to receive the feeding for 18 hours per day from 6:00 AM until 12 MN (midnight)	F 693	September 05, 2024 by DNS and ADNS regarding the expectation that all residents receiving tube feeding will have the correct rate and type of feeding infusing as ordered. Beginning on September 17, 2024, the DNS, ADNS, or Unit Manager will audit all residents receiving tube feeding daily for two weeks, then three times per week for four weeks to ensure all tube feedings are infusing at the ordered rate and type. Findings of these audits will be reported and discussed monthly for three months in Quality Assurance Performance Improvement (QAPI) meeting and adjusted as needed, beginning on October 17, 2024.	

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F 693	Continued From page 5 A record review of the "Admission Record" for Resident #1 revealed that the facility admitted the resident on 6/6/2008. The resident's diagnoses included Dysphagia, Aphasia, and Unspecified Intellectual Disabilities.	F 693		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/18/24

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F 880	Continued From page 6 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent the possible transmission of diseases and infections by storing clean durable medical equipment	F 880	The Director of Nursing Services (DNS) corrected the deficient practice as it relates to the storage of clean durable medical equipment (DME) on September	

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F 880	Continued From page 7 (DME) in a room marked for biohazard materials for two (2) of three (3) days of survey. Findings include: Review of the facility's, "Policies and Practices - Infection Control", dated 11/1/2017, revealed, " ...This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage the transmission of diseases and infections ..." On 9/3/24 at 11:27 AM, in an observation of the biohazard room and interview with Maintenance #1, revealed the room was clearly marked as a biohazard area. Inside the room, a biohazard container with a red bag was placed on the right side, while oxygen concentrators, covered in plastic bags, were located on the left side of the room. Maintenance #1 stated the oxygen concentrators were considered "clean" since they were bagged, though he acknowledged the room was marked as a biohazard area. In a subsequent observation and interview on 9/4/24, at 9:41 AM, with Registered Nurse (RN) # 1 the same biohazard room was observed. On the right side, the biohazard container with the red bag was still present, while on the left side, the oxygen concentrators with plastic coverings remained. Additionally, an unclean bedside commode was placed on top of the concentrators. RN #1 acknowledged that while the biohazard room was technically considered "dirty," she believed the concentrators were clean because staff had cleaned and bagged them. On 9/4/24 at 9:59 AM, in an interview with the	F 880	04, 2024 by removing the oxygen concentrators from the biohazard room, disinfecting them, and storing them in a clean storage area. All residents have the potential to be affected by the deficient practice. On September 05, 2024, the DNS and Assistant Director of Nursing Services (ADNS) initiated education with all staff members regarding Infection Prevention and Control and the expectation that no clean DME will be stored in the biohazard room. Beginning on September 09, 2024, daily audits were initiated for one week, completed by DNS, ADNS, or Unit Manager, to ensure no clean DME was stored in the biohazard area. Beginning on September 17, 2024, the DNS, ADNS or Unit Manager will audit the biohazard room daily for two weeks, then three times per week for four weeks to ensure no clean DME is stored in the biohazard room. Findings of these audits will be reported and discussed monthly for three months in Quality Assurance Performance Improvement (QAPI) meeting and adjusted as needed to ensure the prevention of possible transmission of diseases and infections, beginning on October 17, 2024.	

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F 880	Continued From page 8 Director of Nursing (DON), she revealed the facility's policy and practices were intended to facilitate maintaining a safe, sanitary comfortable environment and to help prevent and manage the transmission of diseases and infections. She confirmed the facility to follow infection control practices by storing cleaned oxygen concentrators in the biohazard room.	F 880		