STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and two (2) Complaint Investigations (CI MS #26660 and CI MS #27032), at the facility from 12/15/24 through 12/18/24. The SA investigated CI MS #26660 for resident/patient/client neglect, quality of care, resident/patient dignity. The SA investigated CI MS #27032, a facility reported incident, for facility resident to resident/ client abuse and cited F689. 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 F550, F656, F658, and F725. The facility had a census of 100 and was licensed for 120 beds.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide supervision to prevent a resident-on-resident altercation when Resident #61 wandered into another resident's room, which resulted in Resident #61 receiving a hematoma to her forehead and an emergency department (ED) visit for one (1) of 22 sampled residents, Resident	F 689	1. On 11/11/24, resident #61 was removed from resident #91's room and was immediately assessed for injuries sustained after the resident to resident altercation. Neurochecks were initiated and resident later was evaluated at local emergency room due to altered level of awareness. On 11/11/24, wander	1/14/25

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

Electronically Signed | 01/11/2025

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F 689	Continued From page 1 #61. Findings included: A record review of the facility's "Investigation Template," dated 11/11/2024, revealed that at approximately 6:20 AM on 11/11/2024, a floor tech summoned help to Resident #91's room. Staff found water on the floor, a water pitcher spilled, and Resident #91 sitting on her bed holding her purse. Resident #91 stated she thought a man was trying to take her belongings and said she "protected herself." Resident #61 was removed from the room and was noted to have a hematoma on the left side of her forehead and redness on the left side of her face. Resident #61 was assisted to her room and transported to a local hospital's ED. A record review of the local hospital's ED report, dated 11/11/2024, revealed that Resident #61 arrived at the ED at 4:51 PM and was discharged at 5:35 PM ...History: Head Injury: Another resident at nursing home hit pt (patient) on head (upper eyebrow) ...Review of Systems ... Positive for wound (hematoma to left forehead) ...Final diagnoses ...Contusion of forehead, injury of head ..." On 12/15/2024 at 10:12 AM, during an observation of Resident #91's room where the altercation with Resident #61 occurred, there was a stop sign with a Velcro closure across the width of the door. During an interview with Resident #69 (Resident #91's roommate) she reported that she did not see the altercation between her roommate and Resident #61 because she was asleep. She reported that Resident #61 occasionally entered their room but stated the incidents decreased	F 689	barrier/stop sign was placed on the entrance door of Resident #91's room to prevent resident #61 from wandering into resident #91 room. On 12/18/24, caregivers were in-serviced by the Administrator on the importance of visual checks and redirection of resident #61 from other resident's rooms for safety. 2. All residents have the potential to be affected by this deficient practice of lack of supervision to prevent accidents. 3. All wandering residents were assessed by the Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS)on 12/18/24 to prevent accidents/hazards. To ensure that the deficient practice does not recur, the DNS/Director of Clinical Education/Administrator in-serviced all staff on redirecting wandering residents to prevent accidents/hazards on 1/6/25-1/9/25. On 1/13/25, to increase accountability, visual checks every 30 minutes for safety (alternated between assigned Certified Nurses Assistant and assigned nurse) were added to residents with high risk for wandering into other resident's room. These visual checks will be documented on the resident's Medication Administration Record (MAR) by the Nurses and on the resident's Point of Care (POC) tasks by the Nursing Assistants. 4. To monitor the performance of our corrective action and to ensure sustainability, the DNS/ADNS will observe	

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F 689	Continued From page 2 after the stop sign was installed. On 12/16/2024 from 9:30 AM to 10:00 AM, during an observation, Resident #61 was observed wandering throughout the facility, sleeping in hallways where she does not reside. Staff redirected her to her hallway after approximately 30 minutes. On 12/18/2024 at 9:50 AM, during an interview, the Administrator stated she was informed of the incident that occurred on 11/11/2024 by the DON and it was discussed during the facility's daily "Stand-Up" meeting. Staff determined interventions such as implementing stop signs and monitoring Resident #61 upon waking should be added. On 12/18/2024 at 11:13 AM, during an interview, the Floor Tech stated that on 11/11/2024 at 6:20 AM, he heard a commotion from Resident #91's room. Upon entering, he saw Resident #91 on her bed and Resident #61 in her wheelchair. He reported that a Training Center Account Manager (TCAM) assisted with removing Resident #61 and cleaning the water on the floor. On 12/18/2024 at 11:16 AM, during an interview, the TCAM stated she entered D-Hall at approximately 6:20 AM and saw the Floor Tech cleaning water. She stated she removed Resident #61 from Resident #91's room and heard Resident #91 say, "Get out, get out, you don't belong in here." On 12/18/2024 at 11:40 AM, during an interview, Registered Nurse (RN) #3 stated she was informed of the incident during her medication pass. She reported the incident to the DON and	F 689	3 high risk residents with increased wandering or agitation for risk of accidents or hazards 3x/week x 4 weeks beginning 12/23/24, then monthly to ensure resident's safety. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25 by the DNS for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	

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F 689	Continued From page 3	F 689		

Nurse Practitioner, completed an incident report, and performed neurological checks.

On 12/18/2024 at 11:50 AM, during an interview, the DON stated she was informed of the incident before arriving at the facility. She ensured residents were separated, reported the incident to the State Agency, and started an investigation. She confirmed the implementation of stop signs on doors of residents who complained about Resident #61 entering their rooms.

A record review of the facility's "Admission Record" revealed the facility admitted Resident #61 on 10/30/2020 with diagnoses including Unspecified Dementia.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/2024 revealed staff assessed Resident #61's cognitive status as severely impaired.