MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17SH	A. BUILDING: _____ B. WING _____	C 03/20/2025

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DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

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M 000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey and seven (7) Complaint Investigations (CI MS #27183, CI MS #27690, CI MS #27865, CI MS #28043, CI MS #28193, CI MS #28208 and CI MS#28282) at the facility from 3/17/25 through 3/20/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M500, M610, M640, M650, M705, M885, M970, M1010, M1210 and M1570. The SA identified non-compliance and cited M610 for failure to provide Activities of Daily Living (ADL's) and M885, M1010, and M1210 for environment related to CI MS #27183. The SA identified non-compliance and cited M610 for ADL's and M650 regarding hydration for CI MS #28043. The SA identified non-compliance and cited M610 for ADL's for CI MS# 28208. The SA identified non-compliance for CI MS #27690 and cited M500 and M610. The SA investigated CI MS #27865, CI MS #28193 and CI MS#28282 with no deficiencies cited. The census at the time of the survey was 134 and the facility was licensed for 140 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and	M 500		4/16/25

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

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

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M 500	Continued From page 3 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse	M 500		

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M 500	Continued From page 4 practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure that resident call lights were within reach, which limited a resident's ability to request assistance as needed for two (2) of 134 residents observed on survey. Resident #32 and Resident #42 Findings include: Review of the facility policy with a revision date of October 2022 titled "Call Lights: Accessibility and Timely Response" revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance... 5. Staff will ensure the call light is within reach of residents and secured, as needed ...6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room..." Resident # 32 An observation and interview on 3/17/25 at 10:30	M 500	1. Resident #32□s Call light was placed within reach of the resident on 03/17/2025 by certified nursing assistant. Resident #42 call light was placed within reach of the resident on 3/17/2025 by certified nursing assistant. Resident #32 and #42 was assessed by the Director of Nursing on 03/17/2025 and no negative outcome was noted for this resident. 2. All residents using call lights have the potential to be affected by this deficient practice. All residents were reviewed by the Director of Nursing on 03/18/25 to ensure call lights were within reach of all residents. 3. To ensure the deficient practice does not reoccur, on 03/24/2025, the Director of Clinical Education provided an in-service for staff on ensuring call lights are within reach of all residents. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit all residents 3 days a week for 6 weeks, then weekly for 6 weeks starting 03/20/2025 to ensure their call lights are within reach. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three	

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M 500	Continued From page 5 AM revealed Resident #32 in bed with the call light wrapped around the side rail on the right side of the bed and hanging out of the resident's reach. When asked how he called the staff for assistance, he stated "I use the call light if I can find it, you can't push what you can't find." An observation of Resident #32's room and interview with Registered Nurse (RN) #2 and Certified Nursing Assistant (CNA) #2 on 3/17/25 at 10:32 AM, they verified that the call light was wrapped around the side rail on the right side of the bed and hanging out of the resident's reach. CNA #2 stated "that is on me, I just left to throw something away and forgot to put it where he could reach it, I was coming back." RN #2 confirmed that the call light should be kept in the resident's reach because if there was a problem or emergency the resident would not be able to call for assistance. Record review of the "Admission Record" revealed that the facility admitted Resident #32 on 01/31/2020 with diagnoses that included Blindness Right Eye and End Stage Renal Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 12/22/24 for Resident #32 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact. Resident #42 An observation on 3/17/25 at 10:25 AM revealed Resident #42 lying in bed asleep; the resident's call light was positioned inside the closed drawer of his nightstand, making it inaccessible.	M 500	months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action.	

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M 500	Continued From page 6 An observation on 3/17/25 at 1:20 PM and again at 3:45 PM revealed the call light hanging down on the left side of the nightstand and was not within reach of the resident. An observation on 3/18/25 at 8:30 AM revealed that Resident #42 was lying in bed; his call light was hanging down from the wall and positioned to the right of the nightstand on the floor, and out of reach of the resident. During an interview and observation on 3/18/25 at 11:16 AM of Resident #42's call light position, CNA #4 confirmed the call light was hanging down from the wall and positioned to the right of the nightstand on the floor and was inaccessible to the resident and had not been accessible all morning. She revealed his call light should always be within reach so we can be notified if he needs anything. An interview on 03/18/25 at 2:15 PM, the Director of Nurses (DON) confirmed that staff are expected to ensure call lights are always within residents' reach. The DON stated, "Residents should always have access to their call lights to request assistance. This is a critical aspect of resident safety and care." A record review of Resident #42's Admission Record revealed he was admitted to the facility on 5/15/16 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall	M 610		4/16/25

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M 610	Continued From page 7 receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide activities of daily living (ADL) care for resident's dependent on staff assistance for three (3) of five (5) residents reviewed for ADL's. (Residents #12, #111, and #118). Findings include: Review of the facility policy titled "ADLs," effective August 2021, revealed the following: "Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choice and preferences." ... Resident #12 An observation on 3/17/25 at 12:05 PM and again on 3/18/25 at 9:20 AM revealed that Resident #12's upper and lower teeth were covered in a thick white substance that adhered to the upper and lower gum lines.	M 610	1. Resident #12 received mouth care by assigned certified nursing assistant on 03/18/2025. On 03/18/2025, resident #12□s care plan was reviewed by the Director of Nursing Services (DNS) to ensure it reflected oral care. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome noted for this resident. Resident #111□s fingernails were cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident□s care plan. On 03/18/2025, resident #111□s care plan was reviewed by the DNS, to ensure it reflected that his fingernails are to be trimmed and cleaned. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. Resident #118□s fingernails was cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident□s care plan. On 03/18/2025, resident #118□s care plan was reviewed by the DNS to ensure it reflected that his fingernails are to be trimmed and cleaned. Resident #118 was assessed by the	

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M 610	Continued From page 8 During an interview and observation on 3/18/25 at 11:00 AM, Certified Nurse Aide (CNA) #6 confirmed Resident #12's teeth were bad and had a bunch of gunk on them. She revealed she honestly thought they looked like it had been quite some time since his mouth had been tended to. During an interview on 03/18/25 at 2:10 PM, Registered Nurse (RN) #3 revealed that Resident #12 has a hospice aide that comes twice a week and provides personal hygiene but admits that it is all of their responsibility to make sure the residents oral care is taken care of. She stated that there is no excuse for a residents' daily oral care to not be completed. During an interview on 3/18/25 at 3:26 PM, the Director of Nurses (DON) revealed that all residents are to be adequately groomed, including oral care. A record review of Resident #12's "Admission Record" revealed he was admitted to the facility on 9/5/23 with diagnoses that included Alzheimer's Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side. Resident #111 An observation and interview on 3/17/25 at 10:54 AM revealed Resident #111's fingernails to be one and one-half (1.5) inches long past the tip of the fingers, jagged in appearance with a brown substance under the nail beds. Resident #111 stated, "I am a diabetic, and the nurse has to cut them. They are sharp, and I don't like them this long. I'm not sure when the last time they were cut and cleaned."	M 610	Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. 2. All residents who require assistance with oral care have the potential to be affected by this deficient practice. All residents who require assistance with activities of daily living have the potential to be affected by not having their fingernails trimmed and cleaned. All residents were reviewed by the Director of Nursing on 03/18/25 to ensure that all residents who require assistance with oral care was done. All residents were checked by the Unit Managers on 03/18/2025 to ensure that all resident□s fingernails were trimmed and clean. 3. To ensure the deficient practice does not reoccur, the Director of Clinical Education began in-services with staff on 3/20/25 to ensure they are aware of residents needing assistance with activities of daily living according to their plan of care; including oral care and fingernails trimmed and cleaned. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 3 days a week for four (4) weeks and then weekly for 8 weeks starting 03/20/2025 to ensure the residents who require assistance with activities of daily living receive services as directed in their plan of care. Findings of audits will be presented to the Quality Assurance and Performance Improvement Committee for a minimum of three months for review and interventions as necessary by the Nursing Home Administrator /Director of Nursing Services beginning on	

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M 610	Continued From page 9 An observation and interview on 3/18/25 at 9:05 AM with Resident #111 revealed she got cleaned up last night by the bath girl but admitted that she didn't get her fingernails cut. Her fingernails remain long and jagged. She revealed the girl who gave her a bath couldn't cut her fingernails because she is diabetic, and the nurse had to cut them. She stated, "I don't know when I will get my fingernails trimmed, but they need them." An interview and observation on 3/18/25 at 11:10 AM CNA #5 revealed she was assigned to the resident today and confirmed that the resident's nails were long and jagged. She revealed that she couldn't cut them since the resident is diabetic, but we are supposed to notify the nurses when we notice the fingernails are long and need to be cut. She revealed she had not reported it to the nurse. During an interview and observation on 3/18/25 at 11:15 AM, Licensed Practical Nurse (LPN) #3 confirmed that the resident is diabetic, and the nurses are responsible for trimming the resident's fingernails. She confirmed Resident #111's nails were long and jagged and needed to be trimmed. Resident #111 stated, "I would like my fingernails cut." During an interview on 03/18/25 at 2:00 PM, the DON confirmed that Resident #111 should receive assistance with their ADLs, including proper nail care. A record review of the "Admission Record" for Resident #111 revealed she was admitted to the facility on 3/21/24 with diagnoses which included Type 2 Diabetes Mellitus and Parkinson's Disease.	M 610	04/14/25.	

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M 610	Continued From page 10 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/25 revealed Resident #111 had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #118 An observation of Resident #118 on 3/17/2025 at 10:15 AM revealed the resident had jagged fingernails approximately one-half (½) inch in length with a dark brown substance present underneath the nail beds. During an interview conducted at the time of the observation, Resident #118 verbalized he did not like his fingernails to be long and could not recall the last time they had been trimmed. A subsequent observation and interview on 3/18/2025 at 10:48 AM was conducted with RN #1, she confirmed that Resident #118's fingernails were long, jagged, and visibly soiled with a dark brown substance under the nail beds. RN #1 further acknowledged the nails appeared untrimmed for a prolonged period and required attention. RN #1 expressed concern that the resident could potentially scratch himself, increasing the risk of skin breakdown or infection due to the dirty nails. During an interview with the DON on 3/18/2025 at 11:10 AM he confirmed that Resident #118 was dependent on staff assistance for personal care and should have already received nail care. A record review of the "Admission Record" for Resident #118 revealed he was admitted on 1/21/2025, with diagnoses including A Need for	M 610		

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M 610	Continued From page 11 Assistance with Personal Care. Record review of the MDS with an ARD of 1/28/25 revealed Resident #118 had a BIMS score of 09, indicating the resident had moderate cognitive impairment.	M 610		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on record reviews, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of six (6) residents receiving dialysis. Resident #32. Findings Include: Review of a statement, on company letter head, dated 3/19/25 and signed by the Administrator (ADM) revealed " Standards of Practice, the expectation set forth by (Proper name of facility) management is that the nurses comply with current standards of practice in terms of following physician's orders and fluid restriction documentation." A record review of the "Order Summary Report" for Resident #32 revealed an order for a one liter (1L) fluid restriction. Nursing was to provide 150 cubic centimeters (cc) on the 7:00 AM-3:00 PM shift, 150 cc on the 3:00 PM-11:00 PM shift, and 100 cc on the 11:00 PM-7:00 AM shift. Dietary	M 650	1. Resident #32 fluid restrictions were reviewed with Nurse Practitioner by Director of Nursing Services(DNS) on 3/20/2025. The fluid restrictions were placed on Medication Administration Record(MAR) and care plan by DNS. Resident #32 was assessed by the Director of Nursing Services on 3/20/2025 with no complications noted related to fluid restriction. 2. All residents with fluid restrictions have the potential to be affected by the deficient practice. By 4/3/2025 all residents with fluid restrictions had been reviewed by Nurse Practitioner and Registered Dietician to determine restriction amount and orders obtained, placed on MAR for monitoring. 3. The Director of Clinical Education and the Director of Nursing Services began in-service on 3/20/25 with nurses to ensure following and documentation of each resident's fluid restrictions daily. 4. To monitor the performance of our corrective action and to ensure	4/16/25

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 650	Continued From page 12 was to provide 12 ounces (oz) of fluids on the breakfast tray, four (4) oz on the lunch tray, and four (4) oz on the dinner tray. A record review of Resident #32's "Electronic Medication Administration Record" (eMAR) documentation of fluid intake from the last two weeks revealed the resident exceeded 1 liter fluid intake daily on the following days; 3/3/25, 3/5/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, and 3/17/25. On 3/18/25 at 8:47 AM, during a review of the eMAR documentation of Resident #32's fluid intake with Licensed Practical Nurse (LPN) #1, she verified that the resident was on a one (1) liter per 24-hour fluid restriction. She confirmed that she only documented the 150 cc she administered during her shift and was unaware of how other nurses documented the resident's intake. She admitted that she did not know if the resident was adhering to the fluid restriction. Upon further review of the eMAR, she was unable to determine the resident's total 24-hour fluid intake. She acknowledged that it appeared the resident may have exceeded the one (1) liter fluid restriction on multiple days but was unsure of the accuracy due to inconsistent documentation. She agreed that accurately monitoring fluid intake is essential for a resident on dialysis to prevent fluid overload. On 3/18/25 at 8:50 AM, during an interview and record review of the eMAR documentation of Resident #32's fluid intake with the Director of Nursing (DON), he confirmed that he was unable to determine if the resident was adhering to his fluid restriction. He agreed that it appeared the resident may have exceeded one (1) liter on multiple days but was unsure how staff were	M 650	sustainability, the Unit Manager or Director of Nursing Services will audit 3 residents 3 times per week x 6 weeks, then weekly for 6 weeks starting 03/20/2025, to ensure fluid restrictions are followed and documented. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action.	

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M 650	Continued From page 13 documenting fluid intake. The DON stated that he was uncertain whether the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts included the fluid the resident received with his meals. During an interview and record review of Resident #32's eMAR fluid intake documentation with the Nurse Practitioner (NP) on 3/18/25 at 10:00 AM, she stated that based on the documentation, it appeared the resident was not adhering to his fluid restriction. However, she could not be certain due to the inconsistent and unclear documentation. She agreed that failure to accurately monitor fluid intake could exacerbate the residents' medical conditions. A record review of the "Admission Record" revealed that the facility admitted Resident #32 on 01/31/2020 with a diagnosis of End-Stage Renal Disease.	M 650		
M 885	45.31.3 Screens and Outside Openings Screens and Outside Openings. Openings to the outside shall be effectively screened. Screen doors shall open outward and be equipped with self-closing devices. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide a safe, clean, and homelike environment for one (1) of 134 residents residing in the facility. (Residents # 17) Findings include: Review of the facility policy titled, "Room Audit,"	M 885	1. Resident #17 Air Conditioner was repaired by the Maintenance Director on 3/18/2025 and housekeeping removed the towels and cleaned the area on 3/18/2025. The 3" gap was repaired and towel removed and the screen was placed on the window by the maintenance director on 3/20/2025. The Resident's overbed table was replaced by the maintenance Director on 3/18/2025.	4/16/25

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M 885	Continued From page 14 with an effective date of September 1, 2014, revealed, "Purpose: To assess resident rooms to identify items that should be repaired, replaced, or addressed to ensure a home-like standard that meets acceptable standards...General Room Appearance - Housekeeping issues should be noted and reported to housekeeping. Damaged drywall, furniture, or non-functioning equipment should be noted, a work order created and addressed accordingly to priority..." Resident #17 During an observation and interview on 3/18/25 at 2:50 PM, the Director of Nurses (DON) confirmed towels were lying on the floor in front of the air conditioner unit. During this observation, it was noted that the resident's window had a white towel stuck in the side, and there was a gap of approximately three (3) inches to the remaining top of the window, which exposed the outside elements. There was no screen in the window. Resident #17 revealed they put that towel in there but didn't stop the whole gap. He revealed the window didn't close. The DON confirmed that the window had a gap of approximately 3 inches with a towel positioned in it and was open to the outside elements. He revealed Resident #17 should have a clean, functional room that is free of outside elements. He revealed this is just not acceptable. During an interview on 3/18/25 at 3:00 PM, the Maintenance Supervisor revealed he was aware of the gap in the window and that he used to have a helper, and he thought that the helper had repaired the window. A record review of Resident #17's "Admission Record" revealed the resident was admitted on	M 885	2. All residents have the potential to be affected by this deficient practice. Resident # 17- The Maintenance Director made rounds in the facility to check and see if there were any other air conditioners that needed repair on 3/18 /2025. The maintenance director checked to see if any other bed side tables needed to be replaced. The maintenance director made rounds on 3/20/2025 to ensure there were no gaps in windows or any missing screens. The Housekeeping supervisor made rounds in the rooms to ensure there were no towels under the Air Conditioners or areas that needed to be cleaned. Any negative findings were repaired on 3/18/2025. 3. On 3/24/25, The Director of Clinical Education provided education to staff regarding reporting and creating work orders for repairs needed. The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. On Resident # 17- 3/17/25 Pest Control Company was contacted by Maintenance to service center due to findings. On 3/24/25 the Director of Clinical Education provided education to staff on notifying Maintenance Director or Administrator of pest in center, placing in maintenance system (TELS) and in pest control sighting book located at each nurse's station.	

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M 885	Continued From page 15 3/31/2021 with diagnoses that included Unspecified Dementia and Anxiety Disorder.	M 885	4. To monitor the performance of our corrective action and to ensure sustainability. The Nursing Home Administrator or the Director of Nursing will make rounds weekly to ensure all rooms are in good repair and there are no pest control issues starting 03/24/25.The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. On Resident # 17- 3/17/25 Pest Control Company was contacted by Maintenance to service center due to findings Any negative findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on April 14, 2025.	
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment	M1010		4/16/25

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M1010	Continued From page 16 should be provided for the food service area. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide a safe, clean, and homelike environment for two (2) of 134 residents residing in the facility. Resident #87 and #95. Findings include: Review of the facility policy titled, "Room Audit," with an effective date of September 1, 2014, revealed, "Purpose: To assess resident rooms to identify items that should be repaired, replaced, or addressed to ensure a home-like standard that meets acceptable standards...General Room Appearance - Housekeeping issues should be noted and reported to housekeeping. Damaged drywall, furniture, or non-functioning equipment should be noted, a work order created and addressed accordingly to priority..." Resident #87 On 3/17/25, at 10:30 AM, and again on 3/18/25, at 11:10 AM, an observation of Resident #87's room revealed multiple large brown spots on the window curtains and four boxes stacked on the floor containing tube feeding supplies. Further observation revealed a broken left bed rail, and an oxygen concentrator covered in a gray and white powdery substance. The wall behind the oxygen concentrator had a dried yellow substance. During an interview with RN #1 on 3/18/25 at	M1010	1. Resident #87 curtains were removed and replaced with blinds on , the bed rail was replaced, the wall behind the O2 concentrator was cleaned/painted by the maintenance director on 3/18/25. The boxes on the floor containing tube feeding supplies were removed by central supply on 3/18/2025. The O2 concentrator was cleaned by the unit manager on 3/18/20025. Resident #95 curtains were removed and replaced with blinds by the maintenance director on 3/18/25. The boxes on the floor containing tube feeding supplies were removed by central supply on 3/18/2025. 2. All residents have the potential to be affected by this deficient practice. Resident #87- The Maintenance Director made rounds in the facility to check and see if there were any curtains that needed to be replaced, bed rails needed to be replaced, and walls needed to be cleaned or painted on 3/18/2025. Central Supply made rounds all the rooms to remove any boxes that contained supplies on 3/18/2025. The Unit managers made rounds to see if any other O2 concentrator needed to be cleaned on 3/18/2025. Any negative findings were repaired or replaced on 3/18/2025. Resident #95- The Maintenance Director made rounds in the facility to check and see if there were any curtains that needed to be replaced on 3/18/2025. Central Supply made rounds all the rooms to	

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M1010	Continued From page 17 11:12 AM, she confirmed the presence of the boxes on Resident #87's floor and revealed that she was informed by central supply that the boxes were to be stored in the resident's room. She mentioned that the boxes were previously kept in central supply but was unsure why they were no longer stored there. RN #1 acknowledged that the boxes on the floor posed a potential hazard for staff and visitors. She also revealed that she reported any broken equipment to maintenance but was unaware of Resident #87's broken bed rail. An interview with the Maintenance Director on 3/18/25 at 2:26 PM revealed that he did not conduct routine room rounds, as department heads completed Embrace rounds. He explained that any necessary repairs were documented in the computer work-order system or reported directly by staff. He revealed he was unaware of Resident #87's broken bed rail. Record review of the "Admission Record" revealed the facility admitted Resident #87 on 01/04/2025 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side. Resident #95 An observation of Resident #95's room on 3/18/2025 at 10:37 AM revealed that the curtains over the windows were stained with large, dark brown marks. Additionally, 10 brown boxes containing various enteral feeding supplies were stacked on the floor. During an interview with RN #1 on 3/18/2025 at 11:12 AM, she confirmed that Resident #95's curtains were dirty and needed to be washed.	M1010	remove any boxes that contained supplies on 3/18/2025. 3. On 3/24/25, The Director of Clinical Education provided education to staff regarding reporting and creating work orders for repairs needed. The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. 4. To monitor the performance of our corrective action and to ensure sustainability. The Nursing Home Administrator or the Director of Nursing will make rounds weekly to ensure all rooms are in good repair and there are no pest control issues starting 03/24/25.The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. Any negative findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on April 14, 2025.	

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M1010	Continued From page 18 She also acknowledged that the boxes on the floor had created clutter and posed a fall risk. RN #1 confirmed that the resident should have a clean and clutter-free environment. An interview with the Administrator on 3/18/2025 at 11:50 AM, she confirmed that Resident #95 should have a clean and safe living environment. Record review of the "Admission Record" revealed Resident #95 was admitted to the facility on 2/12/2024 with a medical diagnosis that included Dysphagia following Cerebral Infarction.	M1010		
M1210	45.40.7 Walls and Ceilings Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This Statute is not met as evidenced by: Level II Pattern Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to maintain walls for a homelike environment for one (1) of 134 residents residing in the facility. Residents #79 Findings include: Review of the facility policy titled, "Room Audit," with an effective date of September 1, 2014, revealed, "Purpose: To assess resident rooms to identify items that should be repaired, replaced, or addressed to ensure a home-like standard that meets acceptable standards...General Room Appearance - Housekeeping issues should be	M1210	1. The hole in Resident #79 was replaced and the metal vent cover was secured on 3/18/2025 by the maintenance director. 2. All residents have the potential to be affected by this deficient practice. Resident #79- The Maintenance Director made rounds in the facility to check and see if holes and vents needed to be repaired. Any negative findings were repaired on 3/18/2025. 3. On 3/24/25, The Director of Clinical Education provided education to staff regarding reporting and creating work	4/16/25

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M1210	Continued From page 19 noted and reported to housekeeping. Damaged drywall, furniture, or non-functioning equipment should be noted, a work order created and addressed accordingly to priority..." Resident #79 An observation of Resident #79's room on 3/17/25 at 11:00 AM revealed a hole in the wall beside the resident's bed, with a metal vent cover hanging out of the hole. An observation of Resident #79's room conducted with RN #1 on 3/18/25 at 10:41 AM confirmed there was a hole in the wall and the vent cover was hanging out. She stated the condition posed a potential hazard because the resident could injure himself on the vent cover or stick his arm into the hole. During an interview on 3/18/25 at 10:54 AM the Administrator confirmed the hole in Resident #79's wall was a hazard and should have been identified and addressed. During an interview on 3/18/25 at 11:04 AM the Maintenance Supervisor revealed he was unaware of the hole in Resident #79's wall until today. He measured the hole as approximately four by six inches in diameter and confirmed staff should have identified the damage and submitted a work order. He stated he makes weekly rounds to check for maintenance concerns but did not have documentation of the rounds conducted. Record review of Resident #79's "Admission Record" revealed the resident was admitted on 5/27/24 with diagnoses that included Obstructive Hydrocephalus.	M1210	orders for repairs needed. The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. 4. To monitor the performance of our corrective action and to ensure sustainability. The Nursing Home Administrator or the Director of Nursing will make rounds weekly to ensure all rooms are in good repair and there are no pest control issues starting 03/24/25.The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. Any negative findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on April 14, 2025.	