STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	C 03/26/2025

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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS# 28356) at the facility on 3/26/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA identified non-compliance and cited F600 and F656 for CI MS# 28356 for failure to implement a residents care plan and failure to transfer a resident from the chair to the bed correctly resulting in the resident sustaining a right femur fracture. The facility remains out of compliance from the previous annual survey conducted 3/20/25. The census at the time of the survey was 134 with a bed capacity of 140 beds.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 600	1. Resident #1 was discharged from	4/16/25

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

Electronically Signed | 04/10/2025

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F 600	Continued From page 1 facility policy review, the facility failed to ensure a resident's right to be free from neglect when the facility staff neglected to refer to the kiosk Kardex to ensure staff transferred the resident with the required number of staff members and failed to use the proper assistive device for one (1) of three (3) residents reviewed. Resident #1 Findings Include: Record review of the facility policy titled, "Lift 4 Care-Safe 4 All" revealed "Purpose: To provide team members guidance with assisting patients and residents to safely reposition or transfer... 7. In order to maintain patients' and residents' safety , patients and residents should be lifted or transferred by the lift and sling, which is deemed appropriate after the lift evaluation is completed." Record review of the facility "Kardex Guidelines" revealed "Purpose: to ensure optimal communication and connection between our caregivers and residents resulting in enhanced quality of care and life... The Kardex will be reviewed daily in clinical startups and updated with any changes in a resident condition. Team members providing care will view the Kardex through the POC (Plan of Care) portal." A record review of the "facility investigation" revealed that on 3/14/25, while Resident #1 was being transferred to bed by Certified Nursing Assistant (CNA) #1, the resident stated, "ow," and CNA #1 eased the resident to the floor. CNA #1 immediately notified the nurse. Upon evaluation, no injury or complaint of pain was noted. After assessing the resident, the Registered Nurse (RN) assisted her back to bed, identifying no apparent injury, bruising, or swelling. However,	F 600	facility on 3/20/25. 2. All residents who require assistance with transfers have the potential to be affected by this deficient practice. All residents□ care plans were reviewed to assure transfer needs were reflected. 3. All resident's lift assessments, care plans, and Kardex's were reviewed by the Interdisciplinary team starting on 3/20/25 and updated as needed. To ensure the deficient practice does not recur, the Director of Clinical Education began in-services on 3/20/25 to ensure that the certified nursing assistants knew how to access the Kardex with return demonstration to provide resident transfer assistance. Residents with any change of condition will be reassessed for transfer needs, discussed at IDT meeting, and care plan and Kardex changed to reflect this change. On 3/20/25 a in-service was started with staff members on abuse and neglect. 4. To monitor the performance of our corrective action and to ensure sustainability, the Director of Nursing Services and Unit Managers on 3/21/25 started reviewing lift assessments, care plans, and Kardex's on all new resident admits, hospital returns, change of condition and annual assessments during clinical start up, five days a week to ensure all assessments, care plans and Kardex are correct. Starting on 3/24/25 the Director of Nursing Service and Unit Managers will observe three residents for three times a week for 6 weeks. Then weekly for 6 weeks to insure the certified nursing assistance are following the	

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F 600	Continued From page 2 within 48 hours, swelling was observed above the right knee. An intervention was provided for comfort, and the physician was notified of the change in conditions. An X-ray revealed a fracture above the previous joint replacement device. The Nurse Practitioner (NP) and the Responsible Party were notified, and Resident #1 was transferred to the local emergency room for further evaluation and treatment. A record review of the Computed Tomography (CT) scan of Resident #1's right knee from the local hospital, dated 3/20/25, revealed an acute comminuted periprosthetic fracture of the distal femoral metaphysis. A record review of the "Lift Transfer Evaluation," dated 4/7/24, revealed that Resident #1 required a total lift with a medium yellow sling for transfers. A record review of a printout of the Kiosk Kardex for Resident #1 revealed the following: "Safety...Two members will assist with transfers with each episode...Lift 4 Care: type of lift, sling size, etc. total lift with medium yellow sling." During an interview with the Administrator on 3/26/25 at 9:15 AM, she verified that the facility investigation confirmed that on the evening of 3/14/25, CNA #1 transferred Resident #1 to bed using a stand-pivot transfer method instead of a lift and had to lower the resident to the ground. During the transfer, the resident said, "ow," but upon assessment by the RN, no injury was noted. She stated that within 48 hours, Resident #1 was moaning during care. Upon assessment by the nurse, the resident's right knee was swollen and tender to touch. The resident was assessed by the NP, who noted swelling but no other signs of	F 600	resident's Kardex and transferring the residents correctly. Findings of audits will be brought by the Nursing Home Administrator/Director of Nursing Services to the Quality Assurance and Performance Improvement Committee meeting beginning with April's Quality Assurance Performance Improvement Committee Meeting on 4/14/2025, for a minimum of three months for review and interventions as necessary.	

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F 600	Continued From page 3	F 600		

trauma. A right knee X-ray was ordered on 3/19/25, and results received on 3/20/25 revealed a fracture of the femoral shaft. The NP was notified, and orders were given to transfer the resident to the hospital.

A record review of the "Progress Notes" from 3/14/25 through 3/20/25 confirmed that on 3/16/25, the resident was moaning during care, prompting the nurse to be notified. The resident was observed to have swelling in the right knee with tenderness to touch. The leg was elevated for comfort, and the NP was notified. On 3/17/25, the resident was assessed by the NP, who noted swelling in the right knee without redness, tenderness, warmth, or pain. The resident was diagnosed with right knee effusion, and the current treatment with diuretics was continued. On 3/19/25, the NP saw the resident again, observing no change in the knee's condition. An X-ray of the right knee was ordered. On 3/20/25, the NP noted that the resident continued to have knee swelling without pain. The X-ray results showed a femur fracture, and the NP ordered the resident's transfer to the emergency room for further evaluation and treatment.

During a telephone interview with CNA #1 on 3/26/25 at 11:32 AM, she confirmed that on the evening of 3/14/25, she transferred Resident #1 from the chair to the bed by standing the resident up and pivoting her to bed. She explained that while the resident was standing in front of the bed, the resident's knees buckled, and she lowered her to the floor. She called the nurse, and they assisted the resident back into bed. CNA #1 stated that the resident "moaned" at some point during the transfer. She added that she had always transferred the resident in this

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F 600	Continued From page 4 manner because that was how she had been taught when hired. She acknowledged being aware that the Kardex on the kiosk provided information on the resident's care needs and transfer status. She also confirmed that, during her orientation, she was instructed to check the Kardex at the beginning of each shift for any changes in the resident's needs or transfer requirements. CNA #1 admitted that she did not realize Resident #1 required a total lift for transfers because she had not checked the Kardex. She agreed that failing to follow the Kardex instructions could result in resident injury. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/10/18 with diagnosis that include dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/25 revealed that Resident #1 has impaired range of motion (ROM) of lower extremities on both sides and maximal assistance for transfers.	F 600		
F 656 SS=G	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	F 656		4/16/25

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F 656	Continued From page 5 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 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 staff interview, record review, and facility policy review the facility failed to implement a resident's care plan when Resident #1 was transferred without the required number of staff members and the use of the proper assistive	F 656	1. Resident #1 was discharged from facility on 3/20/25. 2. All residents who require assistance with transfers have the potential to be affected by this deficient practice. All	

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F 656	Continued From page 6 devices for one (1) of three (3) residents care plans reviewed. Resident #1 Findings Include: Record review of the facility policy titled, "Comprehensive Care Plans" revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ..." A record review of the "facility investigation" revealed that on 3/14/25, while Resident #1 was being transferred to bed by Certified Nursing Assistant (CNA) #1, the resident stated, "ow," and CNA #1 eased the resident to the floor. CNA #1 immediately notified the nurse. Upon evaluation, no injury or complaint of pain was noted. After assessing the resident, the Registered Nurse (RN) assisted her back to bed, identifying no apparent injury, bruising, or swelling. However, within 48 hours, swelling was observed above the right knee. An intervention was provided for comfort, and the physician was notified of the change in conditions. An X-ray revealed a fracture above the previous joint replacement device. The Nurse Practitioner (NP) and the Responsible Party were notified, and Resident #1 was transferred to the local emergency room for further evaluation and treatment. Record review of the Comprehensive Care plan for Resident #1 revealed, under "Focus I have a physical functioning deficit with transfers and require assistance from team members and an (proper lift name) total lift. Under Interventions : (proper lift name) total lift with medium yellow sling ...Two (2) members will assist with transfers with each episode"	F 656	other residents care plans and Kardex were reviewed by the Director of Nursing Service and Unit Manager starting on 3/21/25 for transfer care needs. 3. All resident's Lift assessments, care plans, and Kardex's were reviewed by the Interdisciplinary team starting on 3/20/25 and updated as needed to reflect the proper equipment needed for transfer. To ensure the deficient practice does not reoccur, the Director of Clinical Education began in-services on 3/20/25 to ensure the certified nursing assistants knew how to access the Kardex with return demonstration of knowledge of the proper equipment needed for each resident's transfer. 4. To monitor the performance of our corrective action and to ensure sustainability, the Director of Nursing Services and Unit Managers on 3/21/25 started reviewing lift assessments, care plans, and Kardex's on all new resident admits, hospital returns, change of condition and annual assessments during clinical start up, five days a week to ensure all assessments, care plans and Kardex are correct. Findings of audits will be brought by the Nursing Home Administrator/Director of Nursing Services to the Quality Assurance and Performance Improvement Committee meeting beginning with April's Quality Assurance Performance Improvement Committee Meeting on 4/14/2025, for a minimum of three months for review and interventions as necessary	

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F 656	Continued From page 7	F 656		

On 3/26/25 at 9:15 AM, during an interview with the Administrator she verified that on the evening of 3/14/25, CNA #1 transferred Resident #1 to bed using a stand-pivot transfer method instead of a lift and had to lower the resident to the ground. During the transfer, the resident said, "ow," but upon assessment by the RN, no injury was noted. She stated that within 48 hours, Resident #1 was moaning during care and an x-ray was ordered that showed the resident had a right femoral shaft fracture.

A record review of a printout of the Kiosk Kardex for Resident #1 revealed the following: "Safety...Two members will assist with transfers with each episode...Lift 4 Care: type of lift, sling size, etc. total lift with medium yellow sling."

During an interview with CNA #2, CNA #3, and CNA #4 on 3/26/25 at 10:00 AM confirmed that the residents Kardex informed them of what the residents' care plans were and should be checked at the beginning of each shift. CNA #2, CNA #3, and CNA #4 all agreed that the Kardex would show how many staff were needed for a resident transfer and what type of lift to use based on the resident's care plan.

On 3/26/25 at 11:32 AM, during a telephone interview with CNA #1 she confirmed that on the evening of 3/14/25 she transferred Resident #1 from the chair to the bed using the wrong type of lift method. She admitted that she did not look at or follow the residents' Kardex or care plan but used the stand pivot method of transfer instead of a total lift. She confirmed that when she stood the resident up and pivoted her to the bed, the resident's knees buckled, and she lowered her to

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F 656	Continued From page 8 the floor. During a follow-up interview with the Administrator on 3/26/25 at 12:00 PM, she stated that the care plan interventions for the total lift automatically "pull" to the Kardex kiosk for the CNAs to follow. She confirmed that it was her expectation that CNAs check the Kardex at the beginning of each shift and follow the care plan interventions. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/10/18 with diagnoses that included dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/25 revealed that Resident #1 has impaired range of motion (ROM) of lower extremities on both sides and maximal assistance for transfers.	F 656		