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 03/26/2025

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) COMPLETE DATE
M 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 of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for CI MS# 28356 for 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.	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 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;	M 500		4/16/25

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 1 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 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,	M 500		

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 2 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; 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;	M 500		

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 3 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 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:	M 500		

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 4 Level III Based on staff interview, record review, and 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	M 500	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 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	

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 5 (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. 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	M 500	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.	

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 6	M 500		

the NP, who noted swelling but no other signs of 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

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 03/26/2025

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) COMPLETE DATE
M 500	Continued From page 7 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.	M 500		