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
	78EH	A. BUILDING: _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 #28132, CI MS #28229, CI MS #28381, CI MS #28401, CI MS #28494, CI MS #28500, and CI MS #28534 at the facility from 4/15/25 through 4/16/25. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA found the facility to not be in compliance with CI MS #28401 and cited M500 for resident's rights. The SA investigated CI MS #28132, CI MS #28229, CI MS #28381, CI MS #28494, CI MS #28500, and CI MS #28534 with no deficiencies cited for those investigations. The census at the time of the survey was 115 with a license for 119 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		5/9/25

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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	M 500		

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 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.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on resident and staff interviews, record review, and facility policy review, the facility failed to identify and provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care, and professional standards of practice to meet resident's physical needs for one (1) of five (5) residents reviewed for quality of care. Resident #3 Findings include: Record review of facility policy titled, "Notification of Change in Patient/Resident Health Status" dated June 2017, revealed, "Purpose: to ensure all interested parties are informed of the patient's/resident's change in health status so that a treatment plan can be developed which is in the best interest of the patient/resident... C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Depending on the nursing assessment appropriate notification may be immediate to 48 hours..." Record review of facility policy titled, "Skin Care Guidelines", dated July 2018, revealed, "Purpose: To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity... When an open area is identified: Implement resident specific interventions immediately... Notify physician and document notification".	M 500	Resident #3 no longer resides in the center. She was assessed by the Nurse Practitioner on 3/24/2025 with no negative findings. All admissions to the center can be can be affected. An audit of residents admitted in past 30 days completed on 4/16/2025 by the Director of Nursing (DNS) to ensure that were resident centered needed care and services were rendered in accordance with the resident's preferences, goals for care, and professional standards of practice to meet resident's physical needs. No additional findings were identified. Education was conducted by the Director of Clinical Education on 4/16/2025 with the nursing department on following standards of practice to ensure each resident is provided care and services in accordance of the residents specific needs and preferences. Education with nursing staff on prompt notification to medical providers or medical director for admission order clarification completed on 4/16/25 by the DCE. Going forward, beginning on 4/16/2025 the Director of Nursing, Assistant Director of Nursing, Health Information Management Coordinator or Director of Clinical Education will review daily all admissions to the center to assure for services are provided and rendered in accordance to the standards of practice. This audit will occur 5 times weekly for 4	

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M 500	Continued From page 5 During a phone interview on 4/16/25 at 8:50 AM, Resident #3 stated she had been admitted to the facility on the afternoon of Friday, 3/21/25. She revealed she had been an insulin-dependent diabetic for several years and had been in the hospital due to cellulitis of a diabetic ulcer to the toe. She acknowledged she administered insulin three times daily prior to each meal and informed the facility nurse of this on admission and prior to her evening meal. She was informed that the doctor did not order her insulin when she was discharged from the hospital. She asked the nurse to notify the provider since she needed her insulin, and she had the continuous glucose monitoring (CGM) device and her blood sugars had not been low. She knew the provider did not discontinue her insulin and felt that the hospital made an error when reconciling her medications at discharge. This continued Saturday, Sunday, and Monday morning. The resident stated that the nurses refused to contact her physician for a clarification regarding her insulin. She stated she also had a diabetic ulcer on her toe and it was covered with a dressing on admission to the facility. She asked about dressing changes, but was told she did not have an order for wound care or dressing changes. She asked the nurse if she would contact the physician for an order for wound care as well as for insulin, but this was not done. The nurses did change the dressing on Saturday and on Sunday, but she was uncertain what they used for the treatment. She asked multiple people on Friday, Saturday, Sunday, and Monday morning about her insulin and wound care, but no one contacted the provider for orders for her needed care. The provider came in on Monday and ordered the wound treatment and was going to order insulin, but the resident told the provider she would continue to use her own insulin pen that she had brought from home since	M 500	weeks, then monthly for 2 months. The results of the audits will be addressed in the in the Quality Assurance and Performance Improvement (QAPI) meeting on 4/30/2025 and then monthly for a minimum of 3 consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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she was transferring to another facility that day or the next day and she did not want that added to her bill.

During an interview on 4/16/25 at 10:20 AM, the Registered Nurse Treatment Nurse stated he had left the building for the day when the resident was admitted from the hospital on 3/21/25 and he did not assess her until Monday 4/24/25. He stated the treatment being used was Hydrofera Blue so he spoke with the Nurse Practitioner and received a new order for collagen with silver for wound care. He stated if he was not in facility when a new resident was admitted, it was the nurses' responsibility to assess and document the wounds and he would measure and take pictures when he returned. He also stated the provider would be notified if the resident needed orders for care.

An interview with the Director of Nursing (DON) on 4/16/25 at 1:55 PM, revealed Resident #3 was admitted to the facility with a diabetic wound on Friday, 3/21/25. She acknowledged the resident had a diagnosis of Type 2 Diabetes Mellitus with long-term current use of insulin, and on the paperwork received from the hospital, her insulin was discontinued at discharge. The DON confirmed that the resident informed the staff that was a mistake and the physician needed to be contacted. Resident #3 had her own insulin pen and was administering her own medication even though the nurses informed her that that was a safety concern, and she had not been assessed for self-administration of medications. She stated a nurse attempted to contact the provider with no response and there was no documentation of this attempt. She acknowledged the Medical Director needed to be contacted if there was no response from other providers, but he was not contacted to

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verify orders for the insulin as well as for the wound care. She stated each resident in the facility had the right to the treatments and medications needed for their well-being and the facility failed to obtain orders for wound care and insulin and therefore, failed to give treatments and medications per those orders for this resident.

Record review of Resident #3's "Clinical Summary" revealed diagnoses of Insulin Dependent Diabetes Mellitus dated 8/15/18 and Type 2 Diabetes Mellitus with long term current use of insulin dated 12/24/24.

Record review of Resident #3's "History and Physical" dated 3/18/25, revealed resident with "history of ...Type 2 Diabetes Mellitus with long-term current use of insulin". Blood glucose at that time was listed as "201 (High) with reference range of 70-110."

Record review of Resident #3's "Discharge Summary" with discharge date of 3/21/25, revealed discharge diagnosis of, "Type 2 Diabetes Mellitus, with long-term current use of insulin".

Record review of Resident #3's "Order Summary Report" for March 2025, revealed an order dated 3/24/25 for "Right great toe diabetic ulcer - clean wound with wound cleanser, pat dry with gauze, apply collagen with silver, cover with small piece of xeroform, secure with 2 x 2 bordered gauze, change daily". No order for insulin was noted on the "Order Summary Report".

Record review of Resident #3's electronic "Medication Administration Record" (EMAR) for March 2025 revealed the resident had no insulin

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administrations listed or documented.

Record review of Resident #3's electronic "Treatment Administration Record" (ETAR) for March 2025 revealed the resident had a treatment to toe ordered on 3/24/25 and received this treatment on 3/25/25. No other treatments were listed or documented as done on the ETAR.

Record review of Resident #3's "Progress Note" dated 3/22/25 at 1400, revealed, "Resident is self medicating herself with her own insulin. She is monitoring BS (blood sugar) with a device. Resident does not have an order for insulin. Charge nurse and Director of Nursing printed off orders and shown her that she was not on the insulin. Will continue to monitor".

Record review of Resident #3's "Progress Notes" "Behavior Charting" dated 3/24/25 at 0812 revealed, "Describe Behavior/Mood, what the resident was doing, interventions attempted and effectiveness: Nurse went into resident's room this AM to check on resident. Resident was upset stating that her medication wasn't correct upon admit. Resident stated, "I'm supposed to be on insulin. I need insulin due to my diagnosis of Diabetes Mellitus and I have to have my insulin. This nurse explained to resident that facility has to follow discharge orders that was sent with her when admitted. This nurse went over medications with resident. Resident then stated, 'they didn't notify me at the hospital that they discontinued my insulin'. This nurse assured resident that her medications would be assessed by Nurse Practitioner (NP) and primary physician. Resident then continued to state, 'That's okay, I have my own insulin that I've been giving myself and I'm keeping it. You're not gonna take it'. This nurse explained to resident that was unsafe.

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Resident then reported that she didn't care and was keeping her insulin. DNS (Director of Nursing Services)/Administration and NP aware".

Record review of "Progress Note" from Nurse Practitioner dated 3/24/25 at 22:59, revealed, "per hospital documentation (Discharge Summary) patient has diagnosis of Type 2 Diabetes with long-term current use of insulin. Patient reports that she has been taking insulin for several years. However, per hospital documentation (After Visit Summary) under the Instructions section, stated for patient to STOP taking: Insulin Aspart 100 unit/milliliter injection (Novolog). Patient currently has a Insulin Aspart Injection Pen on her bedside table and states that she is using her pen to give herself insulin. Patient states, she takes Insulin Aspart 15 units before (AC) meals. Blood sugars noted with fluctuations. Ranging from 112-366 since admission on 3/21. NP offered to restart insulin. Patient states, no don't order me any insulin, I will just continue to use my own insulin, because I'm leaving today or tomorrow anyway."

Record review of "Progress Note" dated 3/24/25 at 12:57 revealed, "Resident is alert and oriented sitting on side of the bed. Resident is incontinent of bowel/bladder. Resident stated that she giving herself her own insulin that she has in her room".

Record review of "Clinical Health Status Evaluation" dated 3/21/25, revealed, "Barriers to Transition ... Wound Care/Skin Integrity". Also, revealed, "Self-Administration medications: Medication-Self Administration - Does the resident wish to self-administer medication? No."

Record review of "Daily Skilled Nurses Note" dated 3/22/25 and 3/23/25, revealed, "Skin ... c. Treatment (per orders/nurses note); d. dressing

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M 500	Continued From page 10 clean, dry, intact ... Wound Observation Nursing Note (enter any other documentation related to wounds): Diabetic Ulcer to right great toe". No information of treatment documented. Record review of "Daily Skilled Nurses Note" dated 3/24/25 revealed, "Resident stated that she was giving herself her own insulin that she has in her room". Record review of RN Treatment Nurse's documentation "Skin and Wound Evaluation" dated 3/24/25, revealed, "Wound appears stable, callus noted to periwound, wound bed dry. Patient reports she has been using Hydrofera Blue as primary wound dressing. Report given to NP and new order received to clean wound with wound cleanser, pat dry with gauze, apply collagen with silver to wound bed, cover with small piece of xeroform, secure with 2 x 2 border dressing, change daily. Patient tolerated treatment well". Record review of Resident #3's "Admission Record" revealed the facility admitted her on 3/21/25. Diagnoses included Type 2 diabetes Mellitus with foot ulcer and Cellulitis of right toe. Record review of Resident #3's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact.	M 500		