STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	**4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301**

(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 five (5) Complaint Investigations (CI MS #27547, CI MS #27597, CI MS #28040, CI MS #28066, and CI MS #28088), at the facility from 3/11/25 through 3/13/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS#28040 was investigated for improper medical equipment and pain, and F-697 was cited. CI MS#27547 was investigated for call bells, resident left wet, resident not groomed, falls, and food not palatable, CI MS# 27597 was investigated for dietary and quality of care/treatment, CI MS#28066 and MS #28088 was investigated for neglect and resident rights and there were no deficiencies cited related to these investigations. The facility held a license for 120 beds and had a census of 97 at the time of the survey.	F 000		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure effective and timely pain management for one (1) of three (3) sampled residents (Resident #5) with multiple cancer diagnoses, including lung, pancreatic, rectal, and glottic cancer and was admitted with	F 697	The plan of correction is to demonstrate compliance by Diversicare of Meridian of the State and Federal requirements cited for pain management during the survey on 3/12/2025.	4/1/25

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

Electronically Signed | 03/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 697	Continued From page 1 physician orders for scheduled and as-needed (PRN) opioid analgesics but did not receive PRN pain medication for approximately twelve (12) hours following his admission, which resulted in unmanaged pain. Findings include: A review of the facility policy titled "Pain Management," dated January 2021, revealed, " ...To provide guidelines for consistent evaluation, management and documentation of pain in order to provide maximum comfort and enhanced quality of life ...Upon admission pain is evaluated ...Findings are recorded in the EMR (Electronic Medical Record) ...Physician notification occurs as indicated for communication of findings and review of need for pharmacological options ..." A record review of the "Admission Record," revealed the facility admitted Resident #5 on 2/14/25 and he had diagnoses including Malignant Neoplasm of Rectum, Pancreas, Glottis, and Bronchus or Lung. A record review of the "After Visit Summary" from the acute hospital, dated 2/14/25, revealed "Instructions" included to start fentaNYL "Start taking on: February 15, 2025" and HYDROmorphone (Dilaudid). The medication list included fentaNYL 50 mcg (last time patch was given was on 2/12/25) and HYDROmorphone 4 mg every four (4) hours as needed. These orders were received by the facility on 2/14/25 at 2:40 PM. A record review of Resident pain level documented on 2/15/25 at 4:52 AM was three (3).	F 697	1. The resident was discharged from the center and did not return. An immediate Adhoc Quality Improvement Plan was initiated on 3/12/25 for medication availability and for meeting pain needs. The medical director was notified by Direct of Nursing Services(DNS) on 3/12/25. The QAPI was reviewed and signed by the Administrator (NHA), Medical Director, Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Director of Clinical Education (DCE) and the Minimum Data Set Nurse (RNAC). Education regarding the medication availability process and meeting pain needs was initiated on 3/12/25 by the Senior Director of Clinical Education for current nursing staff on duty. 2.To determine if any other residents were affected by this practice, the Director of Nurses audited each resident who was admitted after 8 PM for the month of February. No other residents were affected. Going forward, any late admission experiencing pain could be affected by this practice. 3.Going forward, to avoid this practice from recurring, the DNS will review each new referral to assure the resident's pain medications are available on admission. The Senior Director of Education reviewed the medication availability process guideline on 3/13/2025. Education was provided to nursing staff by the Senior Director of Clinical Operations and the Director of Clinical Education	

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F 697	Continued From page 2 A record review of the Nurse Practioner (NP) note, dated 2/15/25, signed at 10:17 AM revealed, "Chief Complaint/Reason for this Visit" was "new patient needs pain medication ...New patient; admitted last night complaints of pain all over. History of cancer; lung. Has a prescription for dilaudid but it is not available at this time. Resident has a fentanyl patch in use with no relief of pain ...Nurse reports that his medications should be arrive tomorrow but resident needs relief now...Orders for this visit Norco 10-325 mg (milligrams) take one tablet by PEG (Percutaneous Endoscopic Gastrostomy) every 12 hours x (times) 2 doses." A record review of the "Transactions by Patient" report revealed LPN #1 removed Hydrocodone 10 mg for Resident #5 on 2/15/25 at 10:46 AM. A record review of the acute care hospital admission records, dated 2/15/25, revealed Resident #5 was, " ...significant for ...lung cancer, rectal cancer, and pancreatic cancer. He has chronic back pain and the right lower extremity pain for which he is on analgesic. He returned because of worsening pain back and right hip. Pain medications were not controlling his pain enough ...Patient ultimately succumbed to his illness on 02/20/2025..." On 3/11/25 at 11:15 AM, during a phone interview with one of Resident #5's family members revealed the resident was admitted to the facility late on 2/14/25 at approximately 10:30 PM, and the facility did not have his pain medication available until the next day on 2/15/25 at around 11:00 AM. She revealed her brother had cancer throughout his body and complained of pain frequently.	F 697	(DCE) on 3/12/2025 and 3/13/2025 to assure staff understood the medication availability process and their responsibility of assuring pain needs of residents are met. Nurses were not permitted to wqrk without receiving the education. DNS and DCE will ensure all nurses have access to the automatic medication dispensing system by the end of 3/12/2025. 4.To assure the corrective action initiated remains in effect and the center is compliant, the DNS will audit every new admissions for one month, then two admissions a week for 2 months to assure newly admitted residents receive effective pain management. An ADHOC QAPI will be held with the medical director on 3/31/2025, and then monthly for 3 months. Any negative findings will be brought to QAPI by DNS monthly beginning 3/31/25 for a minimum of 3 months. The QAPI committee will review the findings and determine if there is a need to alter our corrective actions.	

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During a phone interview on 3/13/25 at 10:14 AM, with License Practical Nurse (LPN) #1 confirmed that the facility did not have the written prescription of hydromorphone in their emergency medications. She reported to work on 2/15/25 at 7:00 AM, the resident's family member informed her of Resident #5's pain, after realizing the facility did not have the medication. She notified the Nurse Practioner (NP) on call, who returned her call to request a pain medication for the resident. The NP ordered Hydrocodone-Apap 10-325 MG for the resident. On 2/15/25 at 10:46 AM, LPN #1 removed the medication from the emergency medication and administered to the resident. He was later transferred to the hospital for evaluation and treatment due to his pulse oximetry was dropping.

On 3/13/25 at 10:21 AM, during an interview with the Director of Nurses (DON), she confirmed that she was aware of Resident #5 being admitted to the facility on 2/14/25 with a hard copy (written) prescription for hydromorphone (Dilaudid). The facility expected for him to arrive at the facility earlier so that the medication would have been delivered by their pharmacy. The DON revealed there was a delay in the resident receiving his pain medication due to their emergency medication did not have his prescribed medication of Dilaudid. The staff contacted the NP on 2/15/25 to obtain an order for pain medication that they kept at the facility.

On 3/13/25 at 3:00 PM, an interview with the Administrator confirmed that the facility policy is to administer pain medication as requested, that the facility failed to give the medication at the requested time, which caused a delay in

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treatment.

On 3/17/25 at 1:00 PM, during a post exit phone interview with Resident #5's other family member, she stated she was at the facility on 2/15/25, at approximately 7:30 AM and the resident stated that he was in pain all night and he was calling out in pain. She stated that his face was red, agitated, and he was coughing. She went to the nurses' station and the night nurse reported that they did not have his medication in the facility, but that they were in the process of contacting the NP to obtain another prescription for a pain medication. The family member reported that she was walking up and down the hall, waiting for the nurse to obtain the resident's pain medication. The family member also reported they brought it to him around 11:00 AM, and Resident #5 kept asking her to take him to the hospital because of his pain.

On 3/17/25 at 2:00 PM, during a post exit phone interview, LPN #2, confirmed that on 2/14/25 she worked the night shift and Resident #5 entered the facility around 8:30 PM, with a hard copy prescription for Dilaudid. She reported that she observed Resident #5 sleeping frequently during the night and he did not complain of pain or use his call light. She revealed that she was not aware that she could have contacted the on-call NP during the night for a pain prescription for medication kept in the emergency kit. LPN #2 stated that a family member came to the facility on 2/15/25 and reported that Resident #5 was in pain.