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|---|---|---|---|
| | 255118 | A. BUILDING _____ B. WING _____ | 05/21/2025 |

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

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey and two (2) Complaint Investigations (CI) MS #28756 and CI MS#29038 at the facility on 5/18/25 through 5/21/25. The SA investigated CI MS#28756 regarding nursing services, quality of care/treatment and resident/patient client neglect with no deficiencies cited. The SA investigated CI MS#29038 regarding abuse with no deficiencies cited. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F584, F641, F657, F725, F812, and F851.<br><br>The facility was licensed for 120 beds and had a census of 98 at the time of survey. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon | F 565 | | 6/23/25 |

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

Electronically Signed | 06/11/2025

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| F 565 | Continued From page 1<br>the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review of resident council minutes, facility policy review, and interviews conducted during the Resident Council meeting, the facility failed to promptly resolve grievances related to condiments and call light response times for 12 of 12 Resident Council members. This failure has the potential to affect 87 residents.<br><br>Cross Reference F725<br><br>Findings Include:<br><br>A review of the facility's Resident Rights and Protections Under State and Federal Law dated 2022 indicates, "You have the right to voice grievances and recommend changes ... to representatives..." and "The nursing home must try to resolve the issue promptly." | F 565 | 1)On 5/20/2025 the District Manager of Dietary DMD reviewed the menus for the remainder of the week and ensure condiments were present in the kitchen to be served with each meal. On 5/21/20285, the Director of Nursing Service (DNS) and Assistant Director of Nursing Services (ADNS) ensured all residents had functioning call lights within reach.<br>2) All residents who receive a meal tray have the potential to be affected by this deficient practice. All residents have the potential to be affected by this practice of untimely response to call lights.<br>3) DMD and Dietary Manager(DM) in-serviced the dietary staff on 5/21/2025 to ensure all trays had condiments appropriate for each meal and if in review prior to meal service for the day | |

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| F 565 | Continued From page 2<br>A review of the facility's Customer Concern (Grievance) Policy, effective date July 2018, indicates, "Support residents' right to voice concerns ... and ensure after receiving a concern, the center actively seeks a resolution ...", and "Customer concerns will have a prompt response..."<br><br>A record review of the Resident Council meeting minutes dated October 16, 2024, and November 20, 2024, confirmed residents raised concerns about the lack of condiments.<br><br>On 05/18/25 at 12:30 PM, an observation of the dining room revealed baked potatoes served to residents with no salt or pepper packets on the trays to season the potatoes. No salt and pepper shakers were observed on the tables.<br><br>On 05/18/25 at 12:55 PM, the State Agent observed Resident #52 having lunch in Styrofoam to-go containers. The resident's lunch consisted of slices of roast beef, carrots, baked potatoes, and a cookie. No condiments were noted on the tray.<br><br>On 05/18/25 at 01:00 PM, during an interview with a Certified Nursing Assistant (CNA), she confirmed that she assisted Resident #52 with lunch and noted the resident had no condiments on her tray, including butter, salt, or pepper. She explained that she went to the kitchen and was informed there was no butter or salt and pepper. She further explained that the dietary manager had announced over the intercom that all meals would be served in Styrofoam to-go containers due to only two kitchen staff working that day.<br><br>On 05/19/25 at 1:30 PM, the Resident Council | F 565 | condiments are not present the DM and Administrator will be notified immediately so the items can be obtained. The Administrator/DNS/ADNS in-serviced staff on timely response to call lights and upon answering call lights if the resident needs something they cannot provide to immediately notify a staff member that can provide the need.<br>4)To monitor the performance of our corrective action and to ensure sustainability, the DM will monitor the menus and invoices with each shipment received that condiments ordered have been received and if not will ensure that items are purchased and provided for meals starting 5/21/25. The DMD will review weekly food order one time per week for 12 weeks ensuring proper condiments are orderd. The DM will track and verify condiments are available and served two meals a day, five days a week for 12 weeks (utilizing the Health Care Services Group (HCSG) Tray line Checklist). DMD will follow up and review compliance weekly for 12 weeks. Any negative findings will be brought to the Quality Assurance Performance Improvement(QAPI) meeting monthly for a minimum of three months beginning 6/23/2025 by the DM for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action. To monitor the performance of our corrective action and to ensure sustainability, the Administrator, DNS, or ADNS will monitor call light response timeliness and conduct 5 patient | |

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| F 565 | Continued From page 3<br>met with the State Agent to discuss concerns raised by residents regarding the quality of care, staff responsiveness, food service, and general facility practices. Resident #14 stated that they pay too much money not to receive basic condiments such as salt, pepper, and butter. Residents reported that no condiments were provided the previous week. Resident #14 stated they were told the absence of condiments was due to milk being wasted on condiment boxes during delivery, and others were told the dietary department was operating on a budget. Resident #32 and Resident #68 reported that call lights often take up to 20 minutes to be answered. Resident #62 stated that during the 11:00 PM to 7:00 AM shift, call lights can go unanswered for up to 30 minutes. Residents alleged that during this shift, staff are often on their personal phones when calls come in and do not respond promptly. Resident #39 shared that she has had to call the facility using her personal phone to be connected to the nurses' station to request assistance because CNAs either took an excessive amount of time to respond or did not respond at all. Resident #14 confirmed similar issues during the day shift, stating that it takes a long time for CNAs to respond to call lights. Resident #68 stated that CNAs sometimes answer a call light only to say they will return but never come back. Resident #72 reported that CNAs often turn off the call light, say they will come back, and by the time they return, she has forgotten what she needed. Resident #39 confirmed that her call light has remained unanswered for more than 30 minutes on multiple occasions. Resident #68 reported that last month, she called 911 for an ambulance because her call light had been ignored for an extended period. | F 565 | interviews daily 5 days a week for 12 weeks to ensure timely response to call lights. Any negative findings will be brought to the QAPI meeting monthly for a minimum of three months beginning 6/23/2025 by the Administrator for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action. | |

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| F 565 | Continued From page 4 | F 565 | | |

On 05/19/25 at 2:46 PM, during an interview, the Ombudsman reported that during her routine visits and rounds at the facility, Certified Nursing Assistants (CNAs) are frequently not present or visible on the units. She stated that when she visits to speak with residents or follow up on areas of potential noncompliance, nurse aides are consistently difficult to locate.

On 05/20/25 at 9:27 AM, during an interview conducted with the Social Services Director, she explained that grievances can be submitted by residents through various channels. She shared that common grievances often involve food preferences, response times to call lights, and missing personal items. Once a grievance form is completed, it is forwarded to the appropriate department. For example, concerns related to call lights are directed to the Director of Nursing (DON), who may then coordinate with Human Resources if necessary. She acknowledged that call light response times tend to be slower during breakfast and lunch tray pass because CNAs are actively engaged in meal service.

On 05/20/25 at 9:43 AM, during an interview with the Activities Director, she confirmed that call light responsiveness has been an ongoing issue within the facility. She reported that while the problem may be resolved for a period, typically about a month, it often recurs. She stated that she documented the issue as a grievance and submitted it to the nursing department.

On 05/21/25 at 9:00 AM, during an interview with the District Manager of Dietary (DMD), she revealed that the truck comes on Wednesday of every week and that last week, she was told something had spilled over the condiments on the

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| F 565 | Continued From page 5<br>truck, and the condiments had to be rejected. The DMD stated that staff could have gone to get condiments from the store so residents could have condiments during meals. She also stated that salt and pepper shakers were on the carts for residents during tray pass. The State Agent did not observe salt and pepper shakers on the trays or in the dining hall during lunch tray pass.<br><br>On 05/21/25 at 11:35 AM, during an interview with the Dietary Manager (DM), she revealed that the condiments on the week's delivery appeared to have spilled milk or ice cream on the box. Although the condiments were sealed inside the box, she rejected the items and sent them back to the provider. The DM admitted to having run out of condiments. The State Agent informed the DM that, according to Resident Council members, the lack of condiments had been documented as an ongoing issue since October and November 2024, and residents reported they also did not have condiments the prior week. | F 565 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the | F 584 | | 6/23/25 |

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| F 584 | Continued From page 6<br>physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview, record review, and facility policy review, the facility failed to provide a comfortable, homelike environment in the resident rooms for three (3) of 32 rooms on the North Unit.<br><br>Findings include:<br><br>A review of the facility's Resident Rights & Quality of Life Policy, Policy#CC-20, effective March 13,2020 indicated: "The patient or resident has | F 584 | 1) On 5/22/2025 work orders written and repairs made in room N2 regarding exposed sheetrock surrounding the air conditioner by Maintenance Director. On 5/22/2025 work orders written for room N2, N4, and N8 regarding exposed wall areas near the door and air-conditioner, chipped paint, and exposed metal on the bottom corner of wall and repairs were made and completed on 6/10/2025 by the Maintenance Director. | |

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| F 584 | Continued From page 7<br>the right to ... receive services in a center environment that is safe, clean, and comfortable ..."<br><br>On 05/19/25 at 10:43 AM, the State Agent (SA) observed exposed sheetrock surrounding the air conditioner in room N2.<br><br>On 05/21/25 at 10:05 AM, during a room tour and interview with the Maintenance Supervisor, rooms N2, N4, and N8 were observed to have exposed wall areas near the door and air conditioner, chipped paint, and exposed metal on the bottom corner of walls. The Maintenance Supervisor stated that the damage in room N8 occurred while moving a bed and confirmed that all identified areas were in need of repair.<br><br>Also, on 05/21/25, during an interview with the Maintenance Supervisor, the SA reviewed maintenance work orders from April to May 2025. The review revealed no documented requests for repairs in room N2 room N4, or room N8. The Maintenance Supervisor admitted that more repair requests are communicated to him verbally during rounds than are formally documented. | F 584 | 2) All resident's have the potential to be affected by this deficient practice. The Maintenance Director made rounds throughout the facility to check and see if any other rooms had exposed sheetrock surrounding the air-conditioners, exposed wall areas near the door and air-conditioner, chipped paint, and exposed metal on the bottom corner of walls. Work orders written, and negative findings were repaired by 6/10/2025.<br>3) On 5/22/2025, the director of Clinical Education provided education to all team members on reporting and creating work orders for any repairs needed. The Maintenance Director will make rounds in 5 rooms 5 days a week to observe for any needed repairs for six weeks and then two times a week for six weeks starting 5/26/2025. The Maintenance Director will check TELS building management daily and make repairs in a timely manner.<br>4) To monitor the performance of our corrective actions and to ensure sustainability, the embrace partners or the Administrator or Director of Nursing Services will make rounds weekly to ensure all rooms are in good repair starting 5/26/25. Any negative findings of audits will be addressed in the Quality Assurance Performance Improvement meetings for a minimum of three months by the Administrator for review and interventions as necessary beginning with QAPI meeting on 6/23/2025. | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)(h)(i)(j) | F 641 | | 6/23/25 |

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| F 641 | Continued From page 8<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and facility policy review, the facility failed to assure accurate coding of the Minimum Data Set (MDS) related to discharge status (Resident #90) and an anticoagulant medication (Resident #14) for two (2) of 23 residents sampled.<br><br>The scope/severity for F641 was increased to E because this tag was cited on the last annual | F 641 | 1) The Registered Nurse Assessment Coordinator(RNAC)modified the Minimum Data Set (MDS) and correctly coded the discharge status for resident #90 on 5/20/2025 and resubmitted. The RNAC modified and removed anticoagulant medication from the MDS on resident #14 and resubmitted on 6/10/2025.<br>2) On 5/20/2025 the RNAC and the Social | |

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| F 641 | Continued From page 9<br>recertification survey 1/25/24. This represents a pattern of deficiency.<br><br>Findings Include:<br><br>A review of the facility's policy, "MDS and Care Plans," dated August 2019, revealed, "...MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines."<br><br>A record review of the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual, dated October 2019, revealed, "...Completion of the RAI... The RAI process has multiple regulatory requirements... (1) the assessment accurately reflects the resident's status..."<br><br>Resident #90:<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #90 on 03/06/25 with diagnoses including fractured femur.<br><br>A record review of the clinical record revealed Resident #90 had an order with an end date of 03/22/25 to "Discharge home..."<br><br>A record review of the "Discharge Summary," dated 03/17/25, revealed Resident #90 would "transfer home..."<br><br>A record review of the facility's "Notice of Transfer or Discharge" revealed that on 03/19/25 the resident was discharged from the facility to home.<br><br>A record review of the Discharge MDS with an Assessment Reference Date (ARD) of 03/19/25 | F 641 | Director(SSD) reviewed discharged residents from 1/25/2024, to date to ensure discharge codes were correct. All residents that discharge have the potential to be affected by this deficient practice.<br>No other residents were affected on the audit performed by the RNAC and SSD. Review of anticoagulant medications coding by RNAC did not reveal any other coding errors.<br>3) On 5/20/2025 the RNAC in-serviced the SSD on the proper coding of discharges on the MDS per the Accuracy of Assessments Policy. RNAC properly coded the MDS and resubmitted the MDS correctly. The RNAC in-serviced the nurses involved with proper coding the MDS section on anticoagulants.<br>4) To monitor the performance of our corrective action and to ensure sustainability, the RNAC will audit each MDS prior to submission for proper discharge coding and anticoagulant coding 5 days a week for 6 weeks, then 3 days a week for 6 weeks starting on 5/20/2025. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 6/23/2025 by the RNAC for review and revisions as necessary. The QAPI committee will review the findings and determine if there is a need to alter our corrective actions. | |

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| F 641 | Continued From page 10 | F 641 | | |

revealed Resident #90 was coded as discharged to a Short-Term General Hospital.

On 05/19/25 at 3:41 PM, in an interview with the Social Services Director (SSD), she acknowledged making an incorrect entry regarding Resident #90's discharge status. The SSD noted it was a simple mistake and confirmed she is responsible for ensuring her sections of the MDS are coded correctly. She affirmed that the importance of having accurate information on the MDS is for proper billing and stated she will be more careful to verify the accuracy of information.

On 05/19/25 at 3:43 PM, in an interview with Registered Nurse (RN) #1, she acknowledged the discrepancy in the MDS, which listed the resident's discharge status as Short-Term General Hospital. RN #1 confirmed it is the responsibility of the discipline that coded their section to assure accuracy before submitting the MDS. She stated the MDS is used for reimbursement, and it is important to include accurate information.

On 05/19/25 at 3:47 PM, during an interview with the Director of Nursing (DON), she stated the MDS nurse is responsible for ensuring the MDS contains accurate information. The DON emphasized the importance of accurate MDS coding to ensure proper billing and stated she expects the MDS nurse to verify information before submission.

Resident #14:

A record review of the "Admission Record" revealed Resident #14 was admitted on 02/23/24 with diagnoses including seizure.

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| F 641 | Continued From page 11<br><br>A record review of the Quarterly MDS with an ARD of 02/11/25 Section N revealed Resident #14 was taking an anticoagulant.<br><br>A record review of the physician's orders and the electronic Medication Administration Record (MAR) for the month of February 2025 revealed there were no anticoagulant medications ordered or administered to Resident #14 during the lookback period.<br><br>On 05/21/25 at 12:00 PM, during an interview, RN #1 explained she was not working in February 2025 and the MDS nurse responsible at the time was no longer employed at the facility. After reviewing Resident #14's physician's orders and MAR, RN #1 confirmed there was no indication the resident was on an anticoagulant medication and that the MDS must have been coded in error.<br><br>On 05/21/25 at 3:24 PM, in an interview with the Administrator, she acknowledged the discrepancies related to discharge status and medication administration on the MDS. She stated that the discipline completing each section of the MDS is responsible for assuring its accuracy. The Administrator explained that accurate MDS coding is necessary to reflect the true picture of the resident's needs and acuity of care. She stated she will provide training to staff on MDS coding expectations. | F 641 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be- | F 657 | | 6/23/25 |

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| F 657 | Continued From page 12<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, record reviews, and facility policy review, the facility failed to revise a care plan for a resident no longer requiring the use of a lift for transfers for one (1) of 23 resident care plans reviewed (Resident #14).<br><br>Findings include:<br><br>A review of the facility's policy, "MDS and Care Plans," dated August 2019, revealed, "...MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines." | F 657 | 1) On 5/21/25, Resident #14's lift assessment, Kardex, care plan were updated by the Resident Nurse Assessment Coordinator (RNAC) to reflect resident #14 independent with transfers.<br>2) All residents who require assistance with transfers have the potential to be affected by this deficient practice. All other residents' lift assessments, care plans and Kardex were reviewed by the Director of Nursing Services(DNS), Assistant Director of Nursing Services(ADNS), | |

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| F 657 | Continued From page 13<br><br>A review of the RAI 3.0 Operations Manual dated October 2019 revealed, "...Planning for Care: Individualized care plans should address strengths and weakness ...Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident ..."<br><br>A record review of Resident #14's "Comprehensive Care Plan" revealed a care plan with a revision date of 05/15/25 stated, "...I have a physical functioning deficit with transfers and require assistance of 1 to two (2) staff as needed..." with interventions listed as Hoyer Total Lift Large (Green) Sling and Invacare Total Lift Large (Green)..."<br><br>During an observation and interview on 05/18/25 at 11:41 AM, the State Agency (SA) observed Resident #14 sitting up in his wheelchair in the hallway. Resident #14 complained that the staff would not let him use the large bathroom in the hallway. He stated he could not get in and out of the bathroom in his room and had difficulty getting on the toilet. He reported he could transfer himself but did need assistance, although it took staff a long time to come and help.<br><br>On 05/19/25 at 12:10 PM, during an interview with Certified Nurse Aide (CNA) #3, she explained Resident #14 is very independent and will do everything for himself. He is to be assisted with transfers but will not wait or even ask for assistance. She stated he requires assistance from one (1) staff member with transfers.<br><br>On 05/19/25 at 12:25 PM, the SA observed | F 657 | RNAC and Unit Manager starting on 5/21/2025 for transfer care needs.<br>3) All residents' lift assessments, care plans, and Kardexs were reviewed by the Interdisciplinary team starting on 5/21/2025 and updated as needed to reflect the proper equipment needed for transfer. To ensure the deficient practice does not recur, the Director of Clinical Education (DCE) began in-service 5/21/25 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.<br>4) To monitor the performance of our corrective action and to ensure sustainability, the DNS and unit managers on 5/21/2025 started reviewing lift assessments, care plans, and Kardexs 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 Kardexs are correct. Findings of audits will be brought by the Administrator or DNS to the Quality Assurance Performance Improvement meeting beginning on 6/23/2025, for a minimum of three months for review and interventions as necessary. | |

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Resident #14 returning to his room with two (2) staff members. During an interview with the Therapy Director, she explained the resident was recently discharged from therapy but was referred back due to his complaint about not being able to use his bathroom. Resident #14 was discharged from therapy with no problems using the bathroom in his room and was walking 10-15 feet with assistance. Resident #14 wheeled himself into the bathroom without concerns, stood, and used the assist bar on the wall. No concerns were noted with the transfer with therapy staff providing contact guard assist.

On 05/19/25 at 2:00 PM, during an interview with Registered Nurse (RN) #2, she explained Resident #14 requires assistance from one (1) staff member, but the resident will not call for assistance.

On 05/19/25 at 2:30 PM, during an interview with the Therapy Director and record review, she confirmed Resident #14 was discharged from therapy back in February 2025 with stand-by guard assistance. Prior to therapy, the resident could not walk or transfer. She confirmed through a record review of Resident #14's "PT (Physical Therapy) Discharge Summary" that the resident was contact guard assist with transfers.

On 05/21/25 at 12:00 PM, during an interview with RN #1, she explained the facility uses ongoing care plans and updates them daily by reviewing physician orders. She stated she uses physician orders and assessments to complete the Minimum Data Sets (MDS) and care plans. She reviewed Resident #14's care plan and confirmed the resident had a care plan for a lift. She uses the lift evaluation to complete the care

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plan, and the last lift evaluation completed for the resident was from 11/24, which indicated the resident required a lift. She confirmed she was unaware that the resident was no longer using a lift but acknowledged there were no current orders for a lift. The care plan had not been revised accurately to reflect the individual's current needs.

On 05/21/25 at 12:45 PM, during an interview with the Assistant Director of Nursing (ADON), she confirmed Resident #14 does not require a mechanical lift. She stated she expects all care plans to be updated according to current resident assessments.

On 05/21/25 at 12:55 PM, during an interview with the Administrator, she confirmed she expects all care plans to reflect an accurate assessment of each resident and be revised according to the RAI guidelines.

A record review of Resident #14's "Admission Record" revealed the facility admitted the resident on 02/23/24 with the diagnoses of Other Seizures, Anxiety Disorder, Unspecified, Delusional Disorders, and Personal History of Traumatic Brain Injury.

A record review of Resident #14's "Order Summary Report" with active orders as of 05/20/25 revealed orders for OT clarification: OT to treat patient three (3) times a week times 2 weeks with therapeutic exercise, therapeutic activity, self-care training, and group to increase safety and independence with functional tasks active on 05/19/25. No orders were noted for a mechanical lift.

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| F 657 | Continued From page 16<br>A record review of Resident #14's "Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section GG revealed the resident required partial/moderate assistance with toilet transfers.<br><br>A record review of Resident #14's PT Discharge Summary revealed dates of service from 01/23/25 through 02/26/25, with discharge at CGA (contact guard assist) for transfers on 02/26/25. | F 657 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35 Nursing Services.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a) Sufficient Staff.<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (f) of this section, licensed nurses; and | F 725 | | 6/23/25 |

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| F 725 | Continued From page 17<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and facility policy review the facility failed to ensure sufficient nursing staff were available to meet the care needs of residents during a shift change on three (3) of six (6) resident halls, as evidenced by the facility having one (1) Certified Nurse Aide (CNA) available during the transition from day shift to evening shift, while three nurses remained at the nurse's station, and five (5) resident call lights were observed activated for approximately 30 minutes without response.<br><br>Cross Reference F565<br><br>Findings include:<br><br>A review of the facility's "Staffing Policy" revealed it is the practice of (Proper Name of Facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staff expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment. The center conducts workforce management meetings daily to discuss open positions and call-ins as related to patient needs. The facility continues to actively recruit staff, offering various incentives.<br><br>On 5/20/25 at 2:30 PM, the State Agency | F 725 | 1) On 5/21/25, Upon notification that five call lights were alarming: Sufficient nursing staff were dispatched to each residents room to provide needs of residents.<br>2) All residents have the potential to be affected by this deficient practice.<br>3) To avoid recurrence of the deficient practice the nursing staff was educated on 5/21/2025 by Director of Clinical Education (DCE), all nursing staff are responsible for answering call lights in a timely manner to ensure residents' needs are met. Education to nursing staff to notify charge nurse when leaving the floor was done on 5/21/2025.<br>4) To monitor the performance of our corrective action and to ensure sustainability, the Charge nurse each shift will ensure sufficient Certified Nursing Assistants( C.N.A.s) are assigned along with breaktime/meal times to ensure sufficient staffing on the unit at all times starting 5/21/25. The Administrator and Director of Nursing Services or Assistant Director of Nursing Services will monitor assignment sheets and floor coverage 5 days a week for 6 weeks, then 3 days a week for 6 weeks starting 5/20/2025. Any negative findings will be brought to the | |

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| F 725 | Continued From page 18<br>observed several lights sounding on the North Wing. One light was on in North A Hall, two call lights were sounding in North B Hall, and two call lights were sounding in North C Hall. The State Agency also observed three nurses at the nurse's station-one sitting and two standing-reporting to the oncoming shift. No one answered the call lights. No CNAs were observed on the floor until 2:45 PM. At that time, CNA #8 arrived for the evening shift on the North Unit and began answering call lights. Resident #11 was heard saying, "Will someone please help me?" Upon entering the room, the resident stated her call light had been on for 30 or 40 minutes and that she needed help.<br><br>On 5/20/25 at 4:10 PM, CNA #2 confirmed there were no CNAs on the floor at 2:55 PM. She also stated she answered the call lights in Rooms N12 and N19. CNA #2 said she did not know where the other CNAs were but confirmed that nurses were present at the nurse's station when call lights were sounding. CNA #2 added that CNAs should notify nurses before leaving the floor and that she had just been informed that CNA #9, scheduled for the North Hall, was sent home on administrative leave at 2:45 PM.<br><br>On 5/20/25 at 4:30 PM, during an interview, the Assistant Director of Nursing (ADON) stated she did not know where the CNAs were and was unaware that the Administrator had sent CNA #9 home on administrative leave until the State Agency asked about the unanswered call lights on the North Hall around 3:00 PM.<br><br>On 5/21/25 at 8:00 AM, Licensed Practical Nurse (LPN) #3 confirmed there were no CNAs on the floor at 2:30 PM on 5/20/25. She was unaware | F 725 | QAPI meeting monthly for a minimum of three months beginning 6/23/2025 by the DNS for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective actions. | |

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that CNAs had left the floor until the State Agency asked to speak with them. She also did not know how long they had been gone. LPN #3 stated CNAs are supposed to report off to the nurses before leaving or going home but often fail to do so. She said administrative staff are aware that CNAs often leave without notification.

On 5/21/25 at 8:10 AM, LPN #1 confirmed she was one of the cart nurses on North Hall during the day shift. She stated she did not know CNA #9 had been sent home on administrative leave and that the CNAs had not informed her they were leaving.

On 5/21/25 at 9:00 AM, CNA #4 confirmed she was assigned to North C Hall. She stated she went outside to dump her barrel before the shift change and did not inform nurses she was leaving the hall.

On 5/21/25 at 9:15 AM, CNA #1 confirmed she was assigned to North A Hall and also did not inform the nurses she was leaving the hall. She explained she went to dump her barrel before the next shift. She did not think to notify the nurse and was unaware CNA #9 had been placed on administrative leave. CNA #1 said the hall is often short-staffed. She stated, "We try to do the best we can with what we have."

On 5/21/25 at 9:30 AM, CNA #6 stated CNAs do not perform walking rounds to explain care to the oncoming shift. She said dayshift CNAs are often gone before the evening shift arrives. CNA #6 confirmed only one evening shift CNA was on the floor when she arrived.

On 5/21/25 at 11:00 AM, CNA #8 confirmed she

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| F 725 | Continued From page 20<br>clocked in at 2:25 PM on 5/20/25. When she arrived on North Hall, call lights were sounding, and no CNAs were on the hall. She observed three nurses at the nurse's station. CNA #8 stated she normally worked as the transportation aide on dayshift but had been working evenings due to staffing shortages. She also confirmed seeing CNAs #4 and #5 outside.<br><br>On 5/21/25 at 11:30 AM, LPN #2 confirmed she was at the nurse's station at 2:30 PM on 5/20/25 receiving report from LPN #1. She stated that CNAs do not conduct walking rounds and that the dayshift CNAs were not on the hall when she arrived, which she did not know until asked by the State Agency. She said she would have helped with call lights if she had known and acknowledged that nurses struggle to assist due to CNA shortages.<br><br>On 5/21/25 at 12:00 PM, the Administrator confirmed she informed CNA #2 around 2:50 PM that CNA #9 had been placed on administrative leave, which left the North Hall down one CNA. She stated she was unaware the other CNAs were not on the hall. The Administrator acknowledged the facility is actively working to increase staffing and confirmed that available shifts are posted for staff to pick up as needed. | F 725 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | F 812 | | 6/23/25 |

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| F 812 | Continued From page 21<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and facility policy review, the facility failed to store food and maintain food quality in accordance with professional standards for food safety related to overly ripe produce and improperly stored foods and unlabeled items during one (1) of three (3) kitchen observations.<br><br>Findings include:<br><br>A review of the facility's policy, "Food Storage: Cold Foods" revised 2/2023, revealed, "...Procedures ...2. All perishable foods will be maintained at a temperature of 41 degrees F or below ..."<br><br>On 05/18/25 at 10:35 AM, during an observation and interview of the kitchen with the Dietary Manager (DM), refrigerator #3 revealed a plastic storage container containing 14 overly ripe cucumbers with white slimy rind, soft and pliable to the touch, and liquid formed at the bottom of the container. A further observation of the pantry revealed one (1) opened bottle of yellow mustard | F 812 | 1) On 5/18/2025, the District Director of Dietary(DMD) discarded all unlabeled food items, expired food items and overly ripe produce and performed 100% audit of dietary department to ensure all items were labeled, dated, and consumable.<br>2) All residents receiving food from the dietary department have the potential to be affected by this deficient practice.<br>3) On 5/19/2025 the Dietary staff and Dietary Manager(DM) were in-serviced on the Health Care Services Group Policy 18: dry food storage and 19: cold food storage by the DMD.<br>4) To monitor the performance of our corrective action and to ensure sustainability, the DM will audit the dietary department 5 days a week for 6 weeks, then 3 days a week for 6 weeks starting 5/18/2025 to ensure all food is labeled, dated, and stored properly and all expired or spoiled food is discarded immediately. Any negative findings will be brought to the Quality Assurance Performance | |

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| | 255118 | A. BUILDING _____ B. WING _____ | 05/21/2025 |

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

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| F 812 | Continued From page 22<br>with the manufacturer's instructions "Best if used by" date of April 17, 2025; one (1) opened gallon-sized bottle of soy sauce with the manufacturer's instructions to "Refrigerate after opening for quality"; 19 overly ripe oranges with green and white bio-growth on the rind; and one (1) overly ripe apple containing a brown soft spot with the interior of the apple exposed. The Dietary Manager acknowledged the overly ripe produce and improperly stored pantry items and stated it is her responsibility to make sure the food is not expired and is stored properly. The DM stated she did not examine the produce that day as she had intended and confirmed the risks of having overly ripe food in the kitchen. The DM noted that going forward she will do a regular check of the produce and pantry items to assure freshness. The DM affirmed that the dietary staff are in-serviced once a month on food safety, which includes lectures and tests.<br><br>On 05/20/25 at 02:30 PM, in an interview with the Administrator, she acknowledged the overly ripe produce and improperly stored foods. The Administrator stated it is the responsibility of the DM to monitor the food supplies for proper storage and spoilage and stated her expectation is that the DM will get a system of organization to stay on top of monitoring food safety. | F 812 | Improvement meeting monthly for a minimum of three months beginning on 6/23/2025 by the DM for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action. | |
| F 851 SS=F | Payroll Based Journal<br>CFR(s): 483.70(p)(1)-(5)<br><br>§483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.<br>Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for | F 851 | | 6/23/25 |

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| F 851 | Continued From page 23 | F 851 | | |

agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(p)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility

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| F 851 | Continued From page 24<br>must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.<br><br>§483.70(p)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by CMS.<br><br>§483.70(p)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and Certification and Survey Provider Enhanced Reports (CASPER) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ) (information of the staffing hours for the appropriate care of the residents) had been corrected before submitting to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed.<br><br>Findings include:<br><br>Review of the provider's CASPER reporting data revealed the facility triggered for excessively low weekend staffing for one (1) of four (4) quarters: October 1, 2024 - December 31, 2024.<br><br>Review of the facility's "Monthly Schedule" dated October, November, and December 2024 revealed the Director of Nursing (DON) worked as supervisor on October 26 and 27, November 3, and December 14 and 29, 2024. She worked on the floor as a nurse on November 5 and December 29, 2024. | F 851 | 1) The center addressed the corrective action by performing a complete audit on 5/20/2025 of the Payroll Based Journal(PBJ) data submitted for the quarter October 1 - December 31, 2024, that was submitted incorrectly to Centers of Medicare and Medicaid Services by the Administrator, Human Resources Coordinator(HR) and Workforce Manager (WFM). HR and WFM were notified of the incorrect data submission on 5/21/2025.<br>2) The center identified that Diversicare of Meridian's star rating, quality measures and all residents at the center have the potential to be at risk by this deficient practice.<br>3)To avoid recurrence of the deficient practice, the Administrator, HR, and WFM was educated on 5/21/2025 by the Regional Direction of Operations on submitting complete and accurate licensed nurse staffing data and daily audit during the daily workforce management meetings for accuracy. | |

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| F 851 | Continued From page 25<br><br>Review of the facility's "Monthly Schedule" dated October, November, and December 2025 revealed the Assistant Director of Nursing (ADON) worked as supervisor on October 6 and 19, November 3, 14, 16, and 17, and December 1 and 29, 2024. The ADON worked on the floor on October 5, 12, 13, and 29, November 22, and December 29, 2024.<br><br>During an interview on 5/19/25 at 11:00 AM with the Director of Nursing (DON), she explained she did not know the facility triggered for low weekend staffing in the first quarter. The DON said she and the Assistant Director of Nursing (ADON) work when the nursing staff is low. The DON revealed that both are salaried employees and were not clocking in and out during the first quarter. The DON said they just started clocking in and out within the last two (2) weeks. The DON also said the only proof they have that they worked is the assignment sheets, where they wrote themselves in. This is not included in the daily Payroll Based Journal.<br><br>During an interview on 5/19/25 at 11:15 AM with Certified Nursing Assistant (CNA) #2, she revealed she is responsible for the schedule for the nurses and CNAs. CNA #2 stated that if the staff members work a different shift or work beyond their routine shift, she goes into the system and corrects the information. If the staff works on the floor but normally performs other jobs, she changes the code to reflect the correct position the staff worked that day. The corporate office is responsible for sending in the PBJ.<br><br>During an interview on 05/20/25 at 09:00 AM with the Administrator, she explained she was not | F 851 | 4) To monitor the performance of our corrective action and ensure sustainability, the Administrator, HR, and the WFM will audit licensed nurse staff data daily during daily WFM meetings beginning 5/21/25 for accuracy. The Administrator, HR, and WFM will audit staffing data weekly for four weeks beginning on 5/21/2025, then monthly for three months for accurate data submission to PBJ. Any negative findings will be brought to the Quality Assurance Performnace Improvement meetings for a minimum of three months beginning on 6/23/25, by the Administrator for review and revision as necessary to ensure compliance is sustained. | |

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| F 851 | Continued From page 26<br>aware the facility triggered in the first quarter of 2025 for excessively low weekend staff. The staffing coordinator corrects the staff punches daily. This goes directly to the corporate office. The Administrator confirmed the facility just started two (2) weeks ago a new process requiring all salaried employees to clock in and out when they work on the floor.<br><br>During an interview with the Director of Payroll, he explained he has not received anything from CMS showing that the facility triggered for excessively low staff for the first quarter. The Director said the PBJ was accepted. | F 851 | | |