

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255293		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2025	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SHELBY				STREET ADDRESS, CITY, STATE, ZIP CODE 1108 CHURCH STREET SHELBY, MS 38774			
(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			F 000			
F 584 SS=D	The State Agency (SA) conducted an annual recertification survey at the facility from 6/29/25 through 7/01/25. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and deficiencies were cited at F584, F656, F677, F851 and F880. The census at the time of survey was 55 and the facility was licensed for 60 beds. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are			F 584			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to maintain a clean, safe, and homelike environment in one (1) of fifty-five (55) resident rooms observed. This deficient practice resulted in a room environment with visible water damage and possible mold growth, which may pose a health risk to the resident occupying the room. Room 36 B. Findings include: A review of the facility ' s policy, " Types of Maintenance, " with no date, revealed, "Routine Maintenance. This is the most frequently done activity of all and is done by performing routine and scheduled maintenance of the property..." On 6/29/2025 at 11:30 AM, during an observation, Room 36 on the B-side was noted to have a large, irregular-shaped light brown and black discoloration on the far wall, extending	F 584			

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F 584	Continued From page 2 approximately two (2) feet across the ceiling and approximately two (2) feet down the wall. On 6/30/2025 at 8:38 AM, during an observation with the Infection Control Nurse, she verified the presence of the large, irregular-shaped light brown and black discoloration extending across the ceiling and wall in Room 36. She explained that the discoloration appeared to be from a water leak. She reported that she was not sure what the discoloration consisted of, but it could be mold. She agreed that a water leak and possible mold could be detrimental to the resident that lived in that area of the room, by causing an infection. On 6/30/2025 at 8:40 AM, during an observation with Maintenance and the Administrator (ADM), they verified the presence of the discoloration in room 36. Maintenance explained that there had previously been a roof leak in that area which he had repaired, but stated he was unaware of the current issue and noted that it had recently rained. A record review of the facility's "Logbook Documentation Task Name: Regular Maintenance and Safety Inspection " revealed documentation completed by Maintenance. On 3/28/2025, the log noted " need roof now, " on 4/30/2025 it indicated "need roof badly, " and on 5/12/2025 it read "roof needs replacing." On 6/30/2025 at 9:48 AM, during an interview with the Administrator, she verified that she was aware of the maintenance and safety inspection entries indicating the roof needed to be replaced. She explained that she had "put in a request" for a replacement, and in the meantime, Maintenance had patched the roof. She agreed	F 584			

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F 584	Continued From page 3 that the discoloration observed in Room 36 could have been caused by the leaking roof. She verified that she had no documentation that a request had been submitted to the corporate office for a new roof. On 6/30/2025 at 10:00 AM, during a further interview with Maintenance, he verified that he would not have documented the need for a new roof on the inspection log if a replacement was not necessary.	F 584			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656			

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F 656	Continued From page 4 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident/staff interview, and record review, the facility failed to implement a comprehensive care plan for nail care for one (1) of 28 sampled residents. Resident #10 Findings Include: The facility provided a statement on letterhead with an effective date of October 2024 that revealed, "Policy: Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change."	F 656			

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F 656	Continued From page 5 Record review of Resident #10's "Care Plan Report" revealed under, "Focus: Self-care deficit due to: Recent surgery for trans metatarsal amputation of left foot." Additionally revealed under, "Interventions/Tasks: Nail, hair, and oral care daily as needed." On 6/29/25 at 11:55 AM an observation and interview with Resident #10 revealed fingernails on both hands were long, jagged, and measured approximately three-eighths (3/8) inches in length from the fingertip. She stated she would like them trimmed and explained that her nails had never been this long before. On 6/30/25 at 9:00 AM an observation and interview with the Administrator confirmed Resident #10's long nails. An interview with the Minimum Data Set (MDS) Nurse on 6/30/25 at 9:52 AM revealed the purpose of the care plan was to provide the necessary resident care and to ensure their needs were met while incorporating the resident preferences. She acknowledged Resident #10's care plan was not followed for nail care. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 5/15/25 with a medical diagnosis of Encounter for Orthopedic Aftercare following Surgical Amputation. Record review of the MDS with an Assessment Reference Date (ARD) of 5/22/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #10 was moderately cognitively impaired.	F 656			

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F 677 F 677 SS=D	Continued From page 6 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to perform nail care for a resident requiring assistance with activities of daily living (ADLs) for one (1) of 28 sampled residents. Resident #10 Findings Include: The facility provided a statement on letterhead that read, " Policy: Proper name of the facility uses Clinical Nursing Skills and Techniques, Perry. Potter, as a supplementary policy and procedure care guide." An observation and interview with Resident #10 on 6/29/25 at 11:55 AM revealed she was lying in bed with long fingernails bilaterally that measured approximately three-eighths (3/8) of an inch long and were jagged. She admitted that staff had told her they would trim them, but no one ever came. She stated that her nails had never been as long as they are now and she wanted them trimmed. An observation and interview with Certified Nurse Aide (CNA) #1 on 6/30/25 at 8:35 AM confirmed Resident #10's long nails. She stated the treatment nurse was responsible for trimming the resident's nails and revealed the resident could scratch herself and get an infection.	F 677 F 677			

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F 677	Continued From page 7 An observation and interview with the Administrator on 6/30/25 at 9:00 AM confirmed Resident #10's nails were long. She revealed the aides or nurses could trim the resident's nails since she was not a diabetic. She acknowledged there was a possibility the resident could scratch and injure herself. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 5/15/25 with a medical diagnosis of Encounter for Orthopedic Aftercare following Surgical Amputation. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #10 was moderately cognitively impaired.	F 677			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for 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	F 851			

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F 851	Continued From page 8 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 must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F 851			

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F 851	Continued From page 9 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, Payroll-Based Journal (PBJ) staffing data review and facility policy review, the facility failed to submit PBJ data accurately to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed. 2nd Quarter 2025 (January 1, 2025, through March 31, 2025) Findings include: Record review of the facility policy titled, "Payroll Based Journal Entry Submission", dated 2022, revealed, "Procedure ...7. Hours that each team member works each day must be submitted. Per CMS training hours and corporate team member hours may be included if the team member is providing direct care or performing direct care duties ..." Review of the "PBJ Staffing Data Report" revealed the facility triggered for excessively low weekend staffing for the 2nd quarter, 2025 (January 1, 2025, through March 31, 2025). During an interview on 6/30/25 at 12:40 PM, the Human Resource Coordinator revealed the facility used a phone application (APP) for their payroll time clock system. At times, the APP did not work properly and during those times, the employee's time was entered manually. The salary employees' time was also entered manually into the facility's payroll system.	F 851			

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F 851	Continued From page 10 An interview with the Workforce Manager on 6/30/25 at 12:45 PM revealed the Administrator, Human Resource Coordinator, and Workforce Manager met every weekday morning to discuss the hours submitted by the clocking system as well as those manually entered to ensure the submitted information was accurate. She revealed the hours submitted into their payroll system were sent to herself and to corporate by the Human Resource Coordinator. During an interview and record review with the Administrator and the Workforce Manager on 7/1/25 at 7:50 AM, the working schedule and the information submitted into the Payroll Based Journal (PBJ) system revealed discrepancies. The Workforce Manager stated she felt the data was submitted into the PBJ system prior to their review and updated changes of the data. The Administrator confirmed that the information submitted during the 2nd quarter did not accurately reflect the staff present due to manually entered information not being entered timely or correctly. She confirmed the facility failed to submit accurate data into the PBJ system which led to an inaccuracy of data submission.	F 851			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880			

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F 880	Continued From page 11 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880			

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F 880	Continued From page 12 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to use Enhanced Barrier Precautions (EBP) for a resident with a peripherally inserted central catheter (PICC) for one (1) of 16 residents on EBP reviewed.(Resident #206). Findings include: Review of the policy titled, "Proper Name Infection Control Guide," dated 2025, revealed Enhanced Barrier Precautions (EBP) refer to the expanded use of PPE (personal protective equipment) and involve the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug-resistant organisms). Nursing home residents with indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. ... Indwelling devices,	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1108 CHURCH STREET SHELBY, MS 38774		
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F 880	Continued From page 13 e.g., (for example) central lines. ... Review of the Order Summary Report for Resident #206 revealed an order for Cefepime Intravenous (IV) solution 2 (two) GM/100 ML (grams/milliliter): administer two grams intravenously twice daily, with a start date of 6/26/25 and an end date of 7/06/25. ... IV-PICC: monitor site every shift for signs/symptoms of infection and/or infiltration every shift to maintain patent IV access and prevent infection, with a start date of 6/16/25. An observation of medication administration on 6/30/25 at 8:25 AM for Resident #206 revealed Registered Nurse (RN) #1 administered Cefepime intravenous solution 2 GM/100 ML via a PICC line to the resident's left upper arm without wearing a gown as required for EBP. In an interview with RN #1 on 6/30/25 at 8:32 AM, she confirmed she failed to apply a gown as part of EBP and acknowledged that she should have because Resident #206 has a PICC line. She stated that the purpose of EBP is to provide an extra layer of protection between staff and the resident to reduce the spread of infection, and that failing to use EBP increased the resident's risk of infection. During an interview with the Administrator on 6/30/25 at 9:48 AM, she confirmed that RN #1 should have used EBP when she administered the antibiotics to Resident #206 via his PICC line. She confirmed that EBP reduces the risk of the spread of infection between staff and residents. She confirmed that failing to use EBP could place the resident at increased risk of infection.	F 880			

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F 880	Continued From page 14 Record review of the "Admission Record" revealed Resident #206 was admitted by the facility on 5/02/25 with a diagnosis of acute osteomyelitis, left femur. Record review of Resident #206's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired.	F 880			