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
	41TM	A. BUILDING: _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS #28953 and CI MS #29165 at the facility on 6/17/25 through 6/18/25. 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 and cited M 700 for both complaints for pharmacy services. The census at the time of the survey was 110 with a license for 119 beds.	M 000		
M 700	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Level II Pattern Based on resident representative interviews, staff interviews, record review, and facility policy review, the facility failed to provide pharmacy services for obtaining medications timely for two (2) of four (4) residents sampled. Resident #1 and Resident #2 Findings include: Record review of facility's letterhead titled, "Standards of Practice", undated, revealed, "The expectation set forth by (facility's name) management is that nurses comply with current standards of practice in terms of following	M 700		7/21/25

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physician's orders".

Record review of facility policy titled, "Resident Rights and Quality of Life Policy", dated 3/13/20, revealed, "It is the policy of (facility's name) that all patients and residents have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center".

Resident #1

During a phone interview on 6/17/25 at 12:10 PM, Resident #1's Representative (RR) revealed the resident was admitted to the facility on the evening on 5/13/25 and was sent to the hospital on 5/14/25 around 10:00 PM. He was admitted with a foot infection and Chronic Obstructive Pulmonary Disease (COPD) and was on medications for these conditions. RR stated he was uncertain if the resident received the medications and treatments needed for his infection and his lung illness prior to him returning to the hospital on 05/14/25.

During a phone interview on 6/17/25 at 3:26 PM, Licensed Practical Nurse (LPN) #1 revealed she had worked with Resident #1, and he had shortness of breath and she administered his as needed respiratory treatments around 3:00 AM and 9:00 PM which were effective. After his 9:00 PM treatment, he complained of chest pain, provider was notified, nitroglycerin was ordered and administered, and resident was sent to the hospital by ambulance. She revealed she was uncertain of any other medications received by the resident on admission. She revealed some medications were in the medication system in the facility, but others came from the pharmacy and if pharmacy had already brought meds to the

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facility, they would bring the ordered meds the next day.

Record review of Resident #1's hospital "Discharge Summary" dated 5/13/25 revealed diagnoses of postoperative wound infection and osteomyelitis of left foot. Review revealed resident was discharged to facility on Vancomycin.

Record review of Resident #1's discharge "Medication List" from hospitalization dated 5/13/25 at 2:53 PM, revealed Vancomycin every 12 hours.

Record review of "Progress Note" dated 5/13/25 at 5:26 PM, revealed, "Resident received to facility via (by) wheelchair van from (local hospital) in wheelchair accompanied via relative. Wound vac to left foot, resident non-weight bearing, morbidly obese. Able to make needs known with clear speech."

Record review of "Order Summary Report" revealed an order for Vancomycin one gram intravenously (IV) two times a day related to acute osteomyelitis of left ankle and foot.

Record review of Electronic Medication Administration Record (EMAR) revealed the resident did not receive the 5/13/25 evening dose or the 5/14/25 morning dose of Vancomycin as ordered.

Record review of "Discharge Summary" for hospitalization dates of 5/14/25 through 5/15/25 revealed "Reason for Hospitalization" was COPD exacerbation.

Record review of Resident #1's "Admission

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Record" revealed he was admitted on 5/13/25 with diagnoses that included Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Infection of the skin and subcutaneous tissue, disruption of external operation surgical wound.

Record review of Resident #1's Minimum Data Set (MDS) dated 5/14/25 did not reveal a Brief Interview for Mental Status (BIMS) score with reason being resident is rarely/never understood.

Resident #2

During a phone interview on 06/17/25 at 1:15 PM, Resident #2's Representative revealed the resident was admitted to the facility from the hospital on 5/27/25 and she stated he was in the hospital for seizures and pneumonia and was on medications for both conditions and these medications were to be continued during the facility stay. She was uncertain if he received his antibiotics for pneumonia and his other medications that the hospital ordered. On 5/31/25, Resident #2 was difficult to arouse and was sent to the hospital.

Record review of Resident #2's "Discharge Summary" dated 5/27/25 revealed discharge diagnoses of status epilepticus and acute respiratory failure. Record review also revealed he was discharged with five more days of antibiotics for aspiration pneumonia. The discharge summary revealed "Medication List at Discharge" which included Amoxicillin and Clavulanate Potassium two times daily.

Record review of Resident #2's "Discharge Summary" with admission date of 5/31/25 revealed resident was admitted to the hospital due to aspiration into airway and sepsis with

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acute hypoxic respiratory failure.

Record review of Resident #2's "Order Summary Report" revealed an order dated 5/27/25 for Amoxicillin and Clavulanate Potassium (Augmentin) two times daily.

Record review of Resident #2's Electronic Medication Administration Record (EMAR) revealed resident did not receive the evening dose of Augmentin on 5/27/25.

During an interview with the Director of Nursing (DON) on 6/18/25 at 3:00 PM, she revealed if a resident is admitted in the late afternoon, the medications might not arrive from the pharmacy until the next day. A medication dispensing system is available in the facility with some medications, but other medications have to come from the pharmacy which was not local. The orders from the hospital are received prior to the arrival of the resident and are entered into the facility's system by the unit manager. If these medications are entered after a certain time, the system puts the start time for the next day, but the medication start time could be entered manually to prompt the nurse to administer the medication. The DON acknowledged that Resident #1 had orders for respiratory medication and antibiotics and he did not receive these as ordered. The DON acknowledged that Resident #2 had orders for antibiotics for pneumonia that he did not receive as ordered. She stated it was the nurses' responsibility to obtain information as to when the dose was last given at the hospital, administer medications as ordered, monitor the residents for any change in condition, and to notify the provider for concerns.

An interview with the Administrator on 6/18/25 at

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M 700	Continued From page 5 3:30 PM, revealed the facility admitted residents from the hospital without the needed medications and pharmacy services to provide physician ordered medications to the residents timely. Resident #1 did not receive the ordered Vancomycin and Resident #2 did not receive the ordered Augmentin. These medications were not available in the facility's medication dispensing system and had to be delivered to the facility from the pharmacy which was not local. She acknowledged that not receiving medications timely and missing doses of medications could lead to complications for the residents. She confirmed that residents were admitted to the facility with specific medication orders and the facility failed to provide pharmacy services to obtain and administer these medications timely for Resident #1 and Resident #2.	M 700		