STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	C 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

(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 a complaint investigation for MS # 17617, MS #17876, and MS #18025 at the facility from 9/2/21 to 9/3/21. The SA was unable to substantiate MS #17617 for assessment and monitoring and failure to notify physician.The SA was unable to substntiate MS# 17876 for Quality of Care and Resident Rights related to safety, pressure ulcers, staffing ,following physician orders and incontinence.The SA was unable to substantiate MS #18025 for assessment and monitoring and services not performed for a PEG site, resident grooming, and misappropriation of clothing and no deficiences were cited. The SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and substantiated MS #18025 related to Admission, Discharge, and Transfer concerning discharge medications and cited F661. At the time of the survey the facility had a census of 114 and held a license for 140 beds.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		10/8/21

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

Electronically Signed | 09/22/2021

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F 661	Continued From page 1 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on observation,staff and responsible party interview, and record review, the facility failed to properly reconcile discharge medications for three (3) of (3) resident discharge summaries reviewed. Review of the facility policy with an effective date of 12/01/07, and a revision date of 07/01/16, titled, "Leave of Absence, Resident Discharge with Medication or Other Change of Status" revealed this policy sets forth procedures relating to orders for medications upon resident leave of absence, discharge , or other change of status. Number 7 revealed Facility staff should review the medication orders and directions for use with the resident or the resident's representative before the resident leaves the facility for leave of absence or discharge with medications. A telephone interview, on 9/2/21 at 1:10 PM with	F 661	Corrective Action: 1. On 9/6/21, Resident #1 and Resident # 15 responsible party were contacted to reconciled resident’s medication by Director of Nursing Services (DNS). The center will properly reconcile discharge medication prior or upon discharging. The Center will review resident discharge summaries with the resident and/or responsible party including discharged instructions. 2. All discharged residents who are discharged with medications have the potential to be affected by our practice. 3. On 9/3/21, DNS and Assistant DNS (ADNS) completed an audit on resident’s discharge summary for medication reconciliation Date audited 8/18/21 to 9/3/21 completed. On 9/3/21, Director of Clinical Educator (DCE) in-serviced nursing staff on resident discharge	

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F 661	Continued From page 2 Resident #1's Responsible Party (RP) revealed that at discharge he was given eight (8) to 10 bubble packs with his wife's name on them. He stated that he gave the pills as directed on the card for 3 or 4 days. Resident #1 was discharged from the facility on Saturday, 8/14/21. Resident #1's RP stated they got home about 6:00 PM. He took Resident #1 for a visit with her primary care physician on Monday after discharge. He stated the doctor looked at her medicine but was more concerned with other issues. He stated that a few days later his wife complained of leg cramps, and they called their doctor on 8/18/21 and was told to leave off the cholesterol medication for a few days. He stated that he kept a check on her blood pressure, and it had been "crazy". He stated that Resident #1's blood pressure was usually around 119/60 and was at that time 140/80. He stated that Resident #1's daughter checked the medications against the discharge list and discovered they did not match. A medication card with Amlodipine 10milligrams (mg) and Atorvastatin 80 mg was sent home with them and was not on the discharge list. He stated that he spoke to the DON concerning this and she apologized for the mistake and told him to throw them away. An interview, on 9/2/21 at 3:05 PM with the Director of Nursing (DON) confirmed she spoke with Resident #1's husband on 8/18/21. She confirmed that he received two cards of medication that were not his wife's. She stated that they had two resident s with the same name and somehow two (2) cards belonging to Resident #2 was sent home with them. She stated that she spoke with Resident #1's husband concerning this, and he said that he would just throw them away. She stated that he said he	F 661	summary, medication reconciliation process, and education with the resident and/or resident's representative upon discharged. 4. Discharge summary monitoring will be begins on 9/3 conducted by the DNS, ADNS, and/or Unit Manager(s) for 3 months: Five (5) days a week x Two (2) weeks, then Three (3) days a week x Two(2) weeks, then One (1) day a week x Eight (8) weeks. On 9/3/21, any findings will be reported immediately to the Quality Assurance (QA) Committee. QA Committee will review findings and center performance by the DNS for compliance for 3 months. A report of findings and performance will be forwarded to the QA committee, consisting of the Medical Director, Administrator, DNS, ADNS, Social Services, MDS Coordinator, DCE, and Workforce Management for review. If compliance is not met, the DNS or designee will re-inserviced and monitoring will continue until compliance is met. Once compliance is met, Administrator and DNS will continue to monitor. Completion Date: 10/8/2021	

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F 661	Continued From page 3	F 661		

wasn't worried about the medications.

An observation on, 9/2/21 at 4:45 PM, with Licensed Practical Nurse (LPN) #1 revealed that Resident #2 had correct medications in the cart ordered for her. A new card for Atorvastatin 80 mg had arrived on 8/30/21 and Amlodipine 10 mg had arrived on 8/23/21.

Record review of physician orders for Resident #1 revealed no orders for Amlodipine 10 mg or Atorvastatin 80 mg.

A telephone interview on 9/3/21 at 10:52 AM with Licensed Practical Nurse (LPN) #2 confirmed that she discharged Resident #1 on 8/14/21. LPN #1 stated that she went over the list of discharge medications with Resident #1's spouse. She confirmed that she did not reconcile the list with the actual medications. She stated that this was the first day she had Resident #1 and she just picked up the cards in the cart that had her name on them. She stated that she was not thinking there was two (2) residents with the same name. She stated that she should have reconciled the medications to prevent giving the resident the wrong medications that could have possibly caused problems. LPN #1 stated that she did not realize there was a box on the discharge summary form to check that a medication reconciliation was done.

An interview on 9/3/21 at 11:13 AM with LPN #3 confirmed that she had discharged Resident #15 from the facility. LPN #3 stated that when residents are discharged the nurse should go down the list of medications with the resident or the responsible party and make sure the name of the medication on the blister pack is the same.

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F 661	Continued From page 4	F 661		

She stated that this is to make sure the resident is getting the right medication and doesn't get discontinued medications. She confirmed that she did not check the box on the discharge form confirming she did a medication reconciliation. She stated that she just realized a while back that the box was there and needed to be checked. She stated that if the box was not checked, it looks like it was not done.

An interview, on 9/3/21 at 4:05 PM with the DON confirmed the nurse should go over each medication. She stated that the nurse probably grabbed the medications and went through them. She stated that she could understand how she may have sent the Atorvastatin because the resident was on that medication, but she should have caught the Norvasc (Amlodipine). The DON stated that the medications should have been reconciled in front of the husband. The DON stated that on 8/18/21 she checked the cart and Resident #2 had all of medications in the cart. She stated that there should have been a name alert on the medication cards.

Record review of the discharge summary forms revealed that LPN #2 discharged Resident #1, LPN #3 discharged Resident #14 and LPN 4 discharged Resident #15. Record review revealed that box #9. Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over the counter) has been completed and reviewed with the patient/legal representative was not checked as done on the discharge summary for Resident #1, #14, or #15.