| 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 _____ | 02/06/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Survey Agency (SA) conducted an annual recertification survey at the facility from 02/03/2020 to 02/06/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F584, F604, F641, F656, F677, and F695.<br><br>At the time of the survey, the census was 130, and the facility held a license for 140 beds. | F 000 | | |
| 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 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; | F 584 | | 3/10/20 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/06/2020 |

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<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 observation, resident interview, staff interview, and facility policy review, the facility failed to provide a clean, homelike environment for nine (9) of 32 resident rooms toured on the East Wing.<br><br>Findings include:<br><br>Review of the facility's "Daily Patient Room Cleaning" policy, dated 01/01/2000, revealed, Steps to do Job: Follow 5-step room cleaning method: 1) Empty Trash. Get the trash out of all rooms first thing. Wipe basket - if necessary replace liner. 2) Horizontal dusting with a cloth & disinfectant wipe all horizontal (flat) surfaces. 3) Spot clean with a cloth and disinfectant; spot clean all vertical surfaces. 4) Dust mop floor. Use dust mop to gather all trash and debris on floor. Sweep to the door; pick up with dust pan. 5) Damp mop floor with germicide solution, working from back corner to door. Use "Wet Floor" sign | F 584 | - On 2/3/2020 Room E 12A - Bathroom was deep cleaned to ensure that all paper and debris were removed from the floor. The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed. The bathtub area was also deep cleaned to ensure that all debris and cobwebs were removed.<br><br>On 2/3/2020 Room E 14 A/B □ Room was deep cleaned to ensure that all paper, dust balls and other dirt were removed from both sides of the room. Bedside table was cleaned and organized. Walls were put on the schedule for repair. Bathroom was deep cleaned to ensure that no substances remained on the floor. All corners and edges were scrubbed to correct identified issues. Trash was cleared from bathroom. All items noted in | |

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| F 584 | Continued From page 2<br>when finished.<br><br>Review of the facility's "Bathroom Cleaning" policy, dated 01/01/2000, revealed, Steps to do Job: Follow 7-step Method: Dry steps - 1) Pull trash. 2) Fill soap, paper dispensers, etc. 3) Dust mop, pick up trash, use dust mop before using water in the room. Wet Steps: 4) Sanitize sinks, light mirror, fixtures, pipes. 5) Sanitize commode, tank, bowl, base. Use brush for inside of bowl. 6) Spot clean - walls, partitions, light switches. 7) Damp mop - Start in far corner, get behind commode, move trash can, mop out the door. Use "Wet Floor" sign when finished.<br><br>On 02/03/2020 at 11:40 AM, during initial tour, the following observations were made of resident rooms on the East Wing:<br><br>Room E 12A - Dirt and debris on the bathroom floor, brown rings of film inside the toilet bowl, and cob webs inside the bathtub.<br><br>Room E 14 A/B - Bedroom floors covered with small scraps of paper, dust balls, and dirt under both beds. Beside tables covered with food debris and small pieces of paper from meals. Walls behind both beds deeply gauged. Bathroom floor had a sticky substance in front of sink, dirt and debris around the edges of floor, trash can overflowing, and a wheelchair with a large trash bag full of personal belongings, toiletries, clothing, lift pads, and heel protectors, sitting in front of the sink.<br><br>Room E 15 A/B - Dust and dirt lined the heater vent, dead bugs and cobwebs behind resident bed and under window sill, paper debris on floor all around resident beds. Bathroom floor had a | F 584 | and on wheelchair in the bathroom were organized and stored properly or removed from the bathroom.<br><br>On 2/3/2020 Room E 15 A/B □ Room was deep cleaned to ensure that all paper, dead bugs and cobwebs behind and under resident□s beds and window sill and other dirt were removed from both sides of the room. Bathroom was deep cleaned to ensure that no substances remained on the floor. All corners and edges were scrubbed to correct identified issues. The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed.<br><br>On 2/3/2020 Room 17A/B □ Bedside table was cleaned and organized. Bathroom was deep cleaned to ensure that no substances remained on the floor. All corners and edges were scrubbed to correct identified issues. The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed. Trash was cleared, mirror cleaned of spots and toothpaste was washed from mirror and wall below mirror.<br><br>On 2/3/2020 Room E 19A/B - Bathroom was deep cleaned to ensure that all paper and debris were removed from the floor. The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed. | |

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| F 584 | Continued From page 3<br>gray and black film in front of the toilet, brown rings of residue in toilet bowl.<br><br>Room E 17 A/B - Bedside tables covered in food debris, and small pieces of paper, bathroom floor had a film in front of toilet with footprints present in it, trash can was over flowing, brown rings of residue in toilet bowl, mirror has water spots, and a white substance splashed on it.<br><br>Room E 19 A/B - Dirt and debris on the bathroom floor, brown rings of film inside the toilet bowl.<br><br>Room E 21 A/B - Brown rings of film inside the toilet, trash can overflowing.<br><br>Room E 26 A/B - Door knob loose and coming off the door, small pieces of paper on floor under beds, and on bedside tables, bathroom sink and mirror splashed with white substance, water spots on the mirror, bathroom light dim, room was dark, water faucet constantly ran and wouldn't shut off.<br><br>Room E 31 A/B - Bathroom floor had film on floor with footprints visible, floor was covered in debris, toilet had a large amount of dried brown substance splattered on the inside of the toilet bowl, toilet paper holder was broken off the wall and lying in the floor, mirror had water spots and a white substance splashed on the bottom.<br><br>Room E 32 A/B - Dirt and debris on the floor behind both beds, bathroom floor had a film with footprints on it, trash can was overflowing, sink had rings of film in it, toilet had brown rings of film in bowl, foot plate and sheet rock was peeled up and cracked outside bathroom door.<br><br>On 02/03/2020 at 12:15 PM, during an interview | F 584 | On 2/3/2020 Room E 21 A/B - The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed. Trash was removed from bathroom.<br><br>On 2/3/2020 Room E 26 A/B □ Door knob for room was corrected immediately. Room was deep cleaned to ensure that all dirt and debris were removed. Bedside tables were cleaned and organized. Bathroom sink, mirror and floors were deep cleaned. Bathroom lights were repaired and bulbs were replaced. Water faucet for room was replaced on 2/4/2020.<br>On 2/3/2020 Room E 31 A/B - Bathroom was deep cleaned to ensure that all paper and debris were removed from the floor. The toilet was deep scrubbed to ensure that all brown rings and other instances of dried brown substances on the inside and outside of the toilet were removed. Toilet paper holder was replaced. Sink, mirror and wall were cleaned and spots and white substances were removed.<br><br>On 2/3/2020 Room E 32 A/B - Room was deep cleaned to ensure that all dirt and debris under resident□s beds were removed from both sides of the room. Bathroom was deep cleaned to ensure that no substances remained on the floor. All corners and edges were scrubbed to correct identified issues. The toilet and sink were deep scrubbed to ensure that all brown rings and other spots on the inside and outside were removed. Trash was removed form bathroom. Sheet rock and cove base replacement were placed | |

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| F 584 | Continued From page 4<br>with Resident #92, who resides on the East Wing, she revealed the room was dirty. Resident #92 stated she rarely saw housekeeping and the bathroom was filthy all the time.<br><br>On 02/03/2020 at 1:30 PM, during an observation and interview with the Resident Representative for Resident #59, who resides on the East Wing, revealed she had asked for the room to be cleaned on multiple occasions, but it falls on deaf ears. Resident #59's room was noted with debris on the air conditioner, dead bugs, cobwebs and debris along the floor board near the window, dirty bathroom floor and toilet with yellow/brown rings inside the bowl.<br><br>During an observation and interview, on 02/03/2020 at 2:15 PM, the Director of Nursing (DON) confirmed the rooms toured on the East Wing were not clean. The DON stated, "This should have been cleaned up by housekeeping. I'm going to let the Administrator know it is a mess over here."<br><br>On 02/03/2020 at 2:20 PM, during interview with the Administrator, he revealed that he had contacted the facility's Housekeeping Services Supervisor and instructed him to get his people over to the building immediately to get it cleaned up. | F 584 | on schedule for repair.<br><br>Resident #92 □ Resident room was deep cleaned as stated in action for room E 31 A/B on 2/3/2020.<br><br>Resident #59 □ Room E 15 A/B was deep cleaned on 2/3/2020 as part of the complete deep clean of the East Unit. Debris on the floor, air conditioner, dead bugs, and cobwebs were cleaned. Floor boards near the window was scrubbed. The toilet was deep scrubbed to ensure that all brown rings and other spots on the inside and outside of the toilet were removed. The entire bathroom floor, including corners and edges, were scrubbed to correct identified issues.<br><br>- All residents in the center have the potential to be affected by this deficient practice. Administrator instructed Housekeeping Account Manager and District Manager to do a 100% deep clean on the West Wing and Rehab Wing before leaving the center on 2/3/2020. All rooms in the center were cleaned as directed. Administrator checked resident rooms before leaving on 2/3/2020 to ensure that rooms were clean and acceptable. There were no further deficient findings. The administrator instructed the center Maintenance Director to do a 100% audit of sink faucets on 3/3/2020 in resident room to ensure no further issues existed. No additional bathroom faucets were discovered not working correctly. Administrator directed Maintenance | |

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| F 584 | Continued From page 5 | F 584 | Director to begin a center room audit on 3/3/2020 to identify issues with walls and cove base in rooms. All identified issues will be placed on the schedule for repair.<br><br>- All housekeeping staff were educated on 2/4/2020 on the Five-Step Daily Patient Room cleaning dated 1/1/2000 by the Account Manager & District Manager. All housekeeping staff were educated on 2/4/2020 on the 7-Step Bathroom Cleaning policy dated 1/1/2020 by the Account Manager & District Manager. Center Engage partners were educated by the Administrator and the center Director of Clinical Education on 2/3/2020 and 2/4/2020 related to the proper way to round on rooms and what should be documented during these rounds so directives can be issued for correction.<br><br>- Center Engage partners will round and document issues found in rooms on East Wing three times per week for 12 weeks then one time per week for three months to ensure that rooms and bathrooms are clean. Rounds will include documenting any identified damages to walls or cove base in rooms. The results of all rounds will be taken to the QAPI meeting on a monthly basis for review. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity. | F 604 | | 3/10/20 |

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| F 604 | Continued From page 6<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and facility policy review, the facility failed to provide ongoing evaluation of a Resident #70's restraint, for one (1) of one (1) resident with a restraint.<br><br>Findings include:<br><br>Review of the facility's "Physical Restraint | F 604 | - Center Resident Nurse Assessment Coordinator completed Physical Restraint Elimination Evaluation on Resident #70 on 2/5/2020. Restraint reduction was unsuccessful for Resident #70 on 2/5/2020.<br><br>- Center Director of Nursing Services | |

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| F 604 | Continued From page 7<br>Guideline" policy, dated June 2017, revealed, Purpose: For each patient/resident to maintain his or her highest practical health or wellbeing in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Process: The Interdisciplinary Team (IDT) care plan needs to address when the restraint is to be used, plans for alternative measures, periodic and routine evaluation for reduction of the device and continued need. When a patient/resident is determined to need a restraint, the Physical Restraint Elimination evaluation "UDA" will be completed at least on a quarterly basis or with a significant change in the patients/residents condition. This evaluation will assist in determining continued need or possible reduction/elimination.<br><br>Review of Resident #70's "Order Summary Report" for February 2020, revealed an order dated 07/26/2016, "May use tray table to wheelchair when out of bed (OOB) to promote socialization and attend activities; Release every two (2) hours and as needed. Every two (2) hours for muscle weakness with abnormal body movements related to Spondylosis without Myelopathy or Radiculopathy, Lumbar Region release every 2 hours times (x) 15 minutes for incontinent care and exercise and every 2 hours as needed."<br><br>Review of the Restraint Evaluation for Resident #70, in Point Click Care (PCC), revealed, "Next Evaluation Due: Restraint Evaluation 29 days overdue - 01/07/2020."<br><br>A review of the Restraint Evaluation for Resident | F 604 | conducted a 100% audit of all restraint evaluation alerts in Point Click Care on 2/5/2020 to determine if further evaluation User Defined Assessments are deficient. There were no other deficiencies noted.<br><br>- Center RNACs educated by the Director of Clinical Education on 3/9/2020 related to completing all assessments required by policy during Quarterly, Comprehensive and change of resident condition assessments on all residents.<br><br>- Center Administrator and Director of Nursing Services will discuss and audit all Resident Assessment alerts Monday through Friday in Daily Clinical Start-up beginning 3/9/2020 for four weeks, then two times per week for three months to ensure an entire cycle of assessments are completed timely. Results of audits will be taken to center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |

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| F 604 | Continued From page 8<br>#70, revealed the last evaluation was completed on 10/09/2019.<br><br>On 02/03/2020 at 12:40 PM, during an observation, Resident #70 was observed sitting in his wheelchair with a locked lap tray in place.<br><br>On 02/05/2020, at 9:39 AM, during an interview with the Director of Nursing (DON), she confirmed the Restraint Assessment was 29 days over due. The DON stated the last assessment was done on 10/09/2019. The DON revealed the assessment should be completed quarterly to determine if the restraint could be decreased and the goal would be to try to use the least restrictive restraint. The DON stated Therapy had worked with him in the past to reduce the restraint, but when they had attempted a trial removal of the lap tray, Resident #70 would try to jump up out of the chair.<br><br>Record review of the Admission Record for Resident #70, revealed he was admitted by the facility on 03/22/2016, with diagnoses which included Postpolio Syndrome, Muscle Weakness, Unspecified Lack of Coordination, Specific Developmental Disorder of Motor Function, Abnormal Posture, Anxiety Disorder, Spondylosis without Myelopathy or Radiculopathy, Lumbar Region, Type 2 Diabetes Mellitus and Other Secondary Hypertension. | F 604 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced | F 641 | | 3/10/20 |

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| F 641 | Continued From page 9<br>by:<br>Based on record review, staff interview and facility policy review, the facility failed to accurately the discharge status on Resident #125's Discharge Return Not Anticipated Minimum Data Set (MDS) Assessment for one (1) of 29 MDS Assessments reviewed.<br><br>Findings include:<br><br>Review of the facility's statement, documented on the facility's letterhead, revealed, it is the policy of the facility that MDS Coding is completed by utilizing the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual.<br><br>Review of Resident #125's Discharge Return Not Anticipated MDS Assessment, with an Assessment Reference Date (ARD) of 12/09/2019, revealed in Section A2100 (Discharge Status), was coded to indicate resident was discharged to an acute hospital.<br><br>Review of Resident #125's Physician Order, dated 12/04/19, revealed, for resident to discharge (D/C) home on 12/07/2019 with family, Home Health, Nursing, Physical Therapy, Occupational Therapy, Certified Nursing Assistant, Durable Medical Equipment hospital bed, and follow up with primary care physician in two (2) weeks.<br><br>Review of the Discharge Summary, with an effective date of 12/06/2019, revealed, Resident #125's discharge date was 12/07/2019, and the discharge destination was home with relative or family. | F 641 | - Center Registered Nurse Assessment Coordinator modified the assessment identified in error to correctly code to accurate discharge destination of Resident #125 on 2/7/2020.<br><br>- Center RNAC department conducted a 100% audit by 3/6/2020 of discharge assessments completed over the last six months to identify any errors in coding discharge destinations. No other residents were identified with incorrect coding for discharge destination. Any inaccurate discharge destinations identified on Material Data Set assessments during the audit will be modified as outlined by the Resident Assessment Instrument manual to correct discharge destination.<br><br>- Center RNACs will have a second person (partner RNAC) review coding of all discharge destinations beginning 3/9/2020 on all discharge assessments prior to the completion and submission of the record. Education provided to Registered Nurse Assessment Coordinators related to coding discharge destinations on MDS conducted on 3/9/2020.<br><br>- Administrator and Director of Nursing Services will audit 100% of discharge assessments weekly or four weeks then monthly for two months in order to ensure compliance. Any identified inaccuracy in discharge destination coding will be corrected as outlined in the RAI manual for correcting the MDS assessment. | |

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|---|---|---|---|
| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 641 | Continued From page 10<br>Review of the "Admin Census", revealed Resident #125's discharge date was 12/09/2019, with a status of "Discharged to home or self care."<br><br>On 02/06/2020 at 10:34 AM, during an interview with the Director of Nursing (DON), she stated Resident #125's discharge date was 12/09/2019, due to the family not having his room at home ready. The DON revealed the resident was originally planned for a 12/07/2019 discharge. The DON stated Resident #125 went home with family and the original discharge summary was dated for 12/07/2019. The DON stated Resident #125 did not go to the hospital, but went home with family on 12/09/2019. The DON confirmed Resident #125's MDS Discharge Assessment, dated for 12/09/2019, was not accurately coded for discharge status. | F 641 | Results of audits will be taken to the center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(ii) Any services that would otherwise be required | F 656 | | 3/10/20 |

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| F 656 | Continued From page 11<br>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).<br>(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 findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, family interview, and facility policy review, the facility failed to develop a care plan related to respiratory care for Resident #99, and failed to implement the care plan related to Activities of Daily Living for Resident #54, #76 and #106, and related to restraint evaluation for Resident #70; for a total of five (5) of 26 care plans reviewed.<br><br>Findings include:<br><br>Review of the facility's "Care Plans" policy, dated | F 656 | - Center Registered Nurse Assessment Coordinator modified the care plan of resident #90 on 2/7/2020 to add respiratory focus and nebulizer treatment to the plan of care.<br><br>Center Director of Nursing Services instructed staff on 2/4/2020 to make an appointment with a manicurist to have fingernails clipped for resident #54. Center transported resident #54 to the manicurist on 2/5/2020 and nails were trimmed. | |

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|---|---|---|---|---|
| F 656 | Continued From page 12<br>June 2017, revealed: "Care Plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change."<br><br>Resident #99<br>On 02/03/2020 at 11:55 AM, during initial tour, an observation was made of Resident #99's nebulizer machine, mask, and tubing laying on her bedside chair.<br><br>Review of Resident #99's care plan, revealed there was no respiratory care plan developed for this resident.<br><br>Review of Resident #99's "Order Summary Report" for February 202, revealed an order, dated 01/10/2020, for Ipratropium-Albuterol Solution 3 milliliters (ml) inhalation for nebulizer treatment as needed for congestion.<br><br>During an interview, on 02/04/2020 at 9:40 AM, the Director of Nursing (DON) revealed Resident #99's current care plan did not address her respiratory status and the need for nebulizer treatments. The DON stated, " It should have been care planned."<br>Resident #54<br>Record review of Resident #54's comprehensive care plan, revealed a care plan developed to address Activities of Daily Living (ADL) self care deficit, with an intervention to provide nail care as needed.<br><br>Record review of the Certified Nursing Assistant (CNA) Kardex, for Resident #54, revealed | F 656 | Center DNS instructed nursing staff to cut fingernails and toenails for resident #76 on 2/5/2020. West Wing Registered Nurse Unit Manager soaked the resident□s nails and trimmed them on 2/5/2020.<br><br>Center staff assisted resident #106 with toileting on 2/4/2020 when the matter was brought to the attention of Registered Nurse #2.<br><br>Center RNAC completed Physical Restraint Elimination Evaluation on Resident #70 on 2/5/2020. Restraint reduction attempted for Resident #70 on 2/5/2020 was not successful.<br><br>- Center RNACs conducted a 100% audit of care plans of current residents on 2/7/2020 to ensure care plans address respiratory focus on all residents who are actively treated for respiratory condition. Any care plans found deficient during the audit will be updated immediately by the Minimum Data Set department.<br><br>DNS and RN Unit Managers conducted a 100% audit of center residents on 2/4/2020 related to nail care for fingernails and toenails. Any residents found requiring nail care had their nails trimmed by 2/6/2020.<br><br>DNS and RN Unit Managers Conducted a 100% rounding at 1:15 pm on 2/4/2020 to ensure that all call lights had been answered and resident received services | |

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|---|---|---|---|---|
| F 656 | Continued From page 13<br>guidance to provide nail care on shower days, Tuesday, Thursday and Saturday on 3-11 shift.<br><br>On 02/03/2020 at 4:07 PM, during an interview and observation, Resident #54 was noted to have jagged and dirty fingernails. Resident #54 revealed he would like for someone to trim and clean his fingernails.<br><br>On 02/04/2020 at 4:38 PM, during an interview with Registered Nurses (RN) #2, she confirmed Resident #54's fingernails were long, jagged, thick, and with a black substance under them.<br><br>On 02/06/2020 at 1:00 PM, an interview with the Minimum Data Set (MDS)/Care Plan Nurse, revealed when she develops the care plan, the interventions pull over to the Kardex for instruction on care for the resident. The MDS Nurse confirmed the Kardex and the Care Plan instructed nursing to provide nail care to Resident #54.<br><br>Resident #76<br>Review of Resident #76's Comprehensive Care Plan, revealed a care plan related to Activities of Daily Living and self care deficit, with an intervention for nail care as needed.<br><br>Record review of the CNA Kardex, revealed Resident #76 was to be provided nail care on shower days, Tuesday, Thursday, and Saturday (7 AM to 3 PM shift).<br><br>During an interview and observation, on 02/03/2020 at 3:38 PM, and 02/04/2020 at 10:20 AM, Resident #76 was noted to have long fingernails on each hand, approximately 1/2 to 3/4 inches long with a black substance under | F 656 | as requested.<br><br>Center Director of Nursing Services conducted a 100% audit of all restraint evaluation alerts in the medical record on 2/5/2020 to determine if further evaluation UDAs are deficient. There were no other deficiencies noted.<br><br>- Interdisciplinary Team will review care plans weekly beginning 3/9/2020 according to the MDS schedule to ensure care plans reflects resident centered care. Education provided to Registered Nurse Assessment Coordinators related to monitoring and completing care plans by the Clinical Reimbursement Specialist conducted on 3/9/2020.<br><br>Direct care staff educated on 2/5/2020 related to providing nail care as outlined on Kardex driven by the resident care plan.<br><br>Center MDS coordinators educated by the Clinical Reimbursement Specialist 3/9/2020 related to reviewing all assessments required by policy during Quarterly, Comprehensive and change of resident condition assessments on all residents.<br><br>- Administrator and Director of Nursing Services will audit 100% of care plans completed each week beginning 3/9/2020 for two weeks then 25% for two weeks then audit 10% monthly for two months to identify any deficiency in addressing respiratory conditions. Results of audits | |

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|---|---|---|---|---|
| F 656 | Continued From page 14<br>them. Resident #76 stated that he needed his nails trimmed and cleaned.<br><br>On 02/04/2020 at 2:30 PM, an interview with Resident #76's spouse, revealed she cut had cut the resident's fingernails earlier that day, because they were in such bad shape. Resident #76's spouse confirmed the fingernails were long, jagged and very dirty.<br><br>During an interview, on 02/06/2020 at 09:49 AM, CNA #4 revealed she had been assigned to Resident #76 and was aware of his long and dirty fingernails. CNA #4 revealed because the resident was a diabetic and his hands were contracted, she had asked Resident #76's wife to see if she could trim his nails. CNA #4 confirmed she should have reported to the nurse the condition of Resident #76's fingernails.<br><br>On 02/06/20 at 1:00 PM an interview with the MDS/Care Plan Nurse confirmed the Kardex and the Care Plan instructed nursing to provide nail care to Resident #76.<br><br>Resident #106<br>Record review revealed the comprehensive care plan related to risk for falls with interventions that include educate Resident #106 to ask for assistance to help her get from and to the bathroom. A care plan was developed for Resident #106 for ADL physical functioning deficit and an intervention to guide nursing to assist with toileting.<br><br>Record review of the CNA Kardex for Resident #106, related to toileting, instructed nursing to toilet the resident when requested, and resident was a fall risk. | F 656 | will be taken to the center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented.<br><br>Director of Nursing, Assistant Director of Nursing and RN Unit Managers will audit 25% of facility residents weekly for four weeks then 10% of center residents for two months to ensure that nail care is being provided appropriately per the Kardex driven by the resident care plan. Results of audits will be taken to the center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented.<br><br>Center Administrator and DNS will discuss and audit all Resident Assessment alerts Monday through Friday in Daily Clinical Start-up beginning 3/9/2020 for four weeks, then two times per week for three months to ensure an entire cycle of assessments are completed timely. Results of audits will be taken to center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |

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| F 656 | Continued From page 15<br><br>On 02/04/2020 at 12:09 PM, during an interview and observation, Resident #106 revealed she had been waiting a long time to be toileted. Resident #106 call light was turned on from 12:47 PM until 01:00 PM (13 minutes), with the surveyor present in the room, when CNA #3 came into the room to deliver the lunch tray. CNA #3 turned off the call light and left the room, without asking the resident if she needed assistance. Resident #106 turned the call light on again. RN #2 walked by Resident #106's room, while her call light was on, to the food cart and preceded to remove a tray. Surveyor revealed to RN #2 that Resident #106 needed assistance. Resident #106 reported to RN #2 she needed to be toileted. RN #2 stated she would get someone to come and help her. At 1:10 PM, two (2) CNAs entered Resident #106's room to toilet her. Resident #106 stated to the CNAs, " I have been trying to get someone to come help me, but couldn't get anyone to come."<br><br>On 02/04/2020 at 12:45 PM, during an interview with RN #2, she revealed CNA #3 told her she needed help handing out the lunch trays, and that Resident #106's call light had been on for a long time. RN #2 revealed anyone should answer a call light, a nurse or any CNA. RN #2 stated a call light should be answered between three (3) to six (6) minutes.<br><br>On 02/06/2020 at 9:26 AM, an interview with CNA #3, revealed she did not see the call light at Resident #106's room going off for 13 minutes. CNA # 3 revealed the reason she turned the call light off when she delivered Resident #106's lunch tray and didn't ask the resident why her light was on, was because she was passing trays and needed to get back to her trays. CNA #3 | F 656 | | |

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|---|---|---|---|---|
| F 656 | Continued From page 16 | F 656 | | |

confirmed Resident # 106 needed assistance with toileting and had a history of falling when trying to transfer or toilet herself without assistance.

Record review of the Quarterly MDS Assessment, with an ARD of 1/15/2020, revealed Resident #106 required extensive assistance with transfers and toileting.

On 02/06/2020 at 10:30 AM, during an interview with the MDS/Care Plan Nurse, she revealed that when she develops the care plan, entries to the care plan pull over to the CNAs Kardex to instruct them on the amount of assistance needed with the residents care. The MDS/Care Plan Nurse confirmed Resident #106's care plan and Kardex indicated for staff to assist resident with toileting. The MDS/Care Plan Nurse revealed call lights should be answered before 13 minutes.
Resident #70
Record review of Resident #70's Care Plan, revealed a focused problem which addressed Resident # 70's use of lap tray related to prior fall with injury, to avoid falls/injury that may be caused by sudden, uncontrolled movements while in wheelchair due to his inability to maintain body positioning. Care plan date initiated was 03/06/2017, with revision on 02/09/2019. Goal: Maintain least restrictive restraint through next review and decrease the risk of injuries, with a Target Date of 03/19/2020. Interventions included to complete appropriate restraint assessment per living center policy and reassess for potential reduction.

On 02/03/2020 at 12:40 PM, during an observation, Resident # 70 was observed sitting in his wheelchair, with a locked lap tray in place,

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| F 656 | Continued From page 17<br>On 02/05/2020, at 9:39 AM, during an interview, the Director of Nursing (DON) confirmed Resident #70's care plan for the restraint was not followed, due to the Restraint Assessment was 29 days overdue, with the last done 10/09/2019. The DON stated they should be done quarterly.<br><br>Record review of Restraint Evaluation for Resident #70, in the facility's Point Click Care (PCC) computer program, revealed, "Next Evaluation Due: Restraint Evaluation 29 days overdue - 01/07/2020." | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, resident interview, family interview, record review and facility policy review, the facility failed to provide Activities of Daily Living (ADL) assistance, for four (4) of 26 residents, Residents #54, #76, #93, and #106.<br><br>Findings include:<br><br>The facility did not have a Policy and Procedure that addressed the different levels of assistance with Activities of Daily Living.<br><br>Resident #54<br>During an observation and interview, on 02/03/2020 at 4:07 PM, Resident # 54 was observed sitting in the dining room. An | F 677 | - Center Director of Nursing Services instructed staff to make an appointment with a manicurist on 2/4/2020 to have fingernails clipped for resident # 54. Center transported resident #54 to the manicurist on 2/5/2020 and nails were trimmed.<br><br>Center DNS instructed nursing staff to cut fingernails and toenails for resident #76 on 2/5/2020. West Wing Registered Nurse Unit Manager soaked the resident□s nails and trimmed them on 2/5/2020.<br><br>Center staff assisted resident #106 with toileting on 2/4/2020 when the matter was | 3/10/20 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 677 | Continued From page 18<br>observation of Resident #54's fingernails revealed they were long, jagged and dirty. Resident # 54's fingernails reveal nails on the left hand were approximately 1/2 to 3/4 inches long, thick, curled and with a black substance underneath the nails. Fingernails on the right hand were approximately 1/2 inches long, with jagged edges and a black substance under each nail. Resident #54 revealed he would like for someone to trim and clean his fingernails.<br><br>On 02/04/2020 at 8:30 AM, an observation of Resident #54's hands revealed the fingernails on both hands were long, with jagged edges and a black substance underneath the nails.<br><br>During an interview, on 02/04/2020 at 4:38 PM, Registered Nurse (RN) #2 confirmed Resident #54's fingernails were long, jagged, thick, and with a black substance under them. RN #2 revealed the Certified Nursing Assistants (CNA) should have reported to Nursing the condition of the resident's nails.<br><br>On 02/05/2020 at 10:25 AM, an interview with the Director of Nursing (DON), revealed Resident #54's fingernails had been trimmed and cleaned.<br><br>Record review of Resident #54's Comprehensive Care Plan revealed a problem which addressed Activities of Daily Living self care deficit, with an intervention for nursing staff to perform nail care as needed.<br><br>Record review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/10/2019, revealed Resident #54 required extensive assistance with personal hygiene. Resident #54 had a Brief | F 677 | brought to the attention of RN #2. Center staff provided a bath for resident #93 on 2/3/2020. His fingernails were cleaned and he was received a shave.<br><br>- DNS and RN Unit Managers conducted a 100% audit of center residents related to nail care on 2/5/2020 for fingernails and toenails. Any residents found requiring nail care had their nails trimmed by 2/6/2020.<br><br>DNS and RN Unit Managers Conducted a 100% rounding at 1:15 pm on 2/4/2020 to ensure that all call lights had been answered and resident received services as requested.<br><br>Center Director of Nursing Services and RN Unit Managers conducted a 100% audit on 2/3/2020 of all bath/shower alerts in the electronic medical record to determine if other residents were documented as needing baths or showers. Residents noted with shower/bath alerts were offered a shower or bath to be completed by 2/6/2020.<br><br>- Direct care staff educated by the Director of Clinical Education on 2/5/2020 related to providing Activities of Daily Living including nail care, answering call lights, providing peri-care and assistance and providing showers/baths timely and appropriately as outlined on residents Kardex driven by the resident care plan.<br><br>- Center Administrator, Director of Nursing, Assistant Director of Nursing and | |

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| 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 |
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| F 677 | Continued From page 19<br>Interview of Mental Status (BIMS) score of 13,which indicated cognitively intact.<br><br>Resident #76<br>On 02/03/2020 at 3:38 PM, an observation of Resident #76's hands, revealed long fingernails, approximately 1/2 to 3/4 inches long, with a black substance under them. Resident # 76's right hand revealed his pinky finger was bent and contracted tightly to the palm of his hand, and the next three (3) fingers were are straight and tight over the pinky finger and against the palm of his hand and the thumb was not contracted. Resident # 76's left hand revealed the pinky finger was contracted downwards onto the palm of his hand, the index finger had a fingernail completely grown over the tip of the finger,and the thumb nail was thick, approximately 3/4 inches long, jagged and with a black substance under the nail. Resident #76 stated he needed his nails trimmed and cleaned.<br><br>On 02/04/2020 at 10:20 AM, during an observation, Resident # 76's fingernails revealed long, jagged fingernails, with a black substance under the nails.<br><br>On 02/04/2020 at 2:30 PM, during an interview with Resident #76's spouse, she revealed that she had cut the resident's fingernails earlier, because they were in such bad shape. Resident #76's spouse confirmed the fingernails were long, jagged and very dirty.<br><br>During an interview, on 02/06/2020 at 9:49 AM, Certified Nursing Assistant (CNA) #4 revealed she was assigned to Resident #76 and was aware of his long and dirty fingernails. CNA #4 revealed because Resident was a diabetic and his hands were contracted, she asked his wife to | F 677 | RN Unit Managers will audit 25% of center residents weekly for four weeks then 10% of center residents for two months to ensure that Activities of Daily Living are being provided appropriately per the Kardex driven by the resident care plan. Results of audits will be taken to the center QAPI committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented.<br><br>Center Administrator and DNS will discuss and audit all resident bath/shower alerts Monday through Friday in Daily Clinical Start-up for four weeks, then two times per week for three months to ensure resident are receiving showers/baths timely. Results of audits will be taken to center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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

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| F 677 | Continued From page 20<br>see if she could trim his nails.<br><br>Record review of the Comprehensive Care Plan for Resident # 76, revealed a problem that addressed physical functioning deficit and self care impairment, with an intervention for nursing staff to provide nail care as needed.<br><br>Record review of the Quarterly MDS Assessment, with an ARD of 12/20/2019, revealed Resident #76 required extensive assistance of one (1) person for personal hygiene.<br><br>Resident #106<br>During an interview, on 02/04/2020 at 12:09 PM, Resident # 106 revealed she had been waiting a long time to be toileted. While surveyor was present in the room, Resident #106 call light was turned on from 12:47 PM until 01:00 PM (13 minutes), when CNA #3 came into the room to deliver the lunch tray. CNA #3 turned off the call light and left the room, without asking the resident if she needed assistance. Resident #106 turned the call light on again. RN #2 walked by Resident #106's room, while her call light was on, to the food cart and preceded to remove a tray. Surveyor revealed to RN #2 that Resident #106 needed assistance. Resident #106 reported to RN #2 she needed to be toileted. RN #2 stated she would get someone to come and help her. At 1:10 PM, two (2) CNAs entered Resident #106's room to toilet her. Resident #106 stated to the CNAs, " I have been trying to get someone to come help me, but couldn't get anyone to come."<br><br>On 02/04/2020 at 12:45 PM, during an interview with RN #2, she revealed CNA #3 told her she needed help handing out the lunch trays, and that Resident #106's call light had been on for a long | F 677 | | |

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|---|---|---|---|
| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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

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|---|---|---|---|---|
| F 677 | Continued From page 21 | F 677 | | |

time. RN #2 revealed anyone should answer a call light, a nurse or any CNA. RN #2 stated a call light should be answered between three (3) to six (6) minutes.

On 02/06/2020 at 09:26 AM, an interview with CNA #3, revealed she did not see the call light at Resident #106's room going off for 13 minutes. CNA #3 revealed the reason she turned the call light off when she delivered Resident #106's lunch tray and didn't ask the resident why her light was on, was because she was passing trays and needed to get back to her trays. CNA #3 confirmed Resident # 106 needed assistance with toileting and had a history of falling when trying to transfer or toilet herself without assistance.

Record review of the Quarterly MDS Assessment, with an ARD of 1/15/2020, revealed Resident #106 required extensive assistance with transfers and toileting.

Resident #93

During an observation and interview, on 02/03/2020 at 12:50 PM, Resident #93 revealed he had not been getting showers like he was supposed to. Resident #93 stated the staff would say they were short staffed, and would just wipe him down later. Resident #93 was noted to have long fingernails, with a brown substance under a few of them, and his beard was unshaven.

A review of the facility's "Shower Schedule", effective 12/12/2019, revealed Resident #93 was scheduled to receive his showers on Tuesday, Thursday, and Saturday, on the 7 AM - 3 PM shift. The schedule documented, "All residents are expected to receive a shower unless they refuse. If Resident refuse a shower, notify the

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|---|---|---|---|
| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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

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|---|---|---|---|---|
| F 677 | Continued From page 22<br>charge nurse."<br><br>Review of Resident #93's Activities of Daily Living (ADL) grid sheet, documented he received a shower on Monday, 01/27/2020 at 10:46 AM; Wednesday, 01/29/2020 at 10:55 AM; and on Monday, 02/03/2020 at 12:43 PM, which were not his scheduled days for showers. There was not documentation of refusals.<br><br>During an interview, on 02/05/2020 at 9:35 AM, the Director of Nursing (DON) revealed the facility did not have a policy for how often residents are to get a bath or shower. The DON stated the resident's shower preferences are put on the CNAs care giver guides, and they have shower schedules in place to refer to. The DON revealed the CNAs should carry the care giver guides in their pockets for reference.<br><br>A review of Resident #93's Significant Change MDS Assessment, with an ARD of 01/10/2020, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. | F 677 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced | F 695 | | 3/10/20 |

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|---|---|---|---|
| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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

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|---|---|---|---|---|
| F 695 | Continued From page 23<br>by:<br>Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to provide storage and cleaning of respiratory equipment to in a manner to prevent potential spread of infection for one (1) of 20 residents reviewed with respiratory equipment, Resident #99.<br><br>Findings include:<br><br>The facility did not provide a policy to address cleaning and/or storage of respiratory equipment.<br><br>On 02/03/2020 at 11:55 AM, during initial tour, an observation was made of Resident #99's nebulizer machine, mask, and tubing laying on her bedside chair, dated 01/10/2020, and uncovered.<br><br>During an observation and interview, on 02/03/2020 at 2:15 PM, the Director of Nursing (DON), was brought to the room to view the uncovered nebulizer equipment, dated for 01/10/2020. The DON removed nebulizer and tubing from the room. The DON stated, "They are to be changed every seven (7) days and as needed if they get soiled. This should have been changed three (3) times since then (01/10/2020) and wasn't."<br><br>During an interview with the DON, on 02/03/2020 at 3:10 PM, she revealed the the facility did not have a written policy for changing nebulizer masks and tubing, but they are ordered to be changed every seven (7) days, dated, and placed in a plastic bag for storage.<br><br>Review of the "Order Summary Report" for | F 695 | - Center Director of Nursing Services removed the nebulizer equipment from the room of Resident #99 on 2/3/2020 and took it to be cleaned and stored properly.<br><br>- Center DNS, Assistant Director of Nursing Services and Registered Nurse Unit Managers audited 100% of residents using nebulizer equipment on 2/4/2020 to ensure that there were orders indicating how often nebulizer equipment tubing should be should be dated, changed and/or stored.<br><br>- Center Director of Clinical Education provided education to center staff on 2/10/2020 related to entering orders for nebulizer equipment tubing and masks changing and/or storage. Education was also provided on 2/10/2020 related to following orders for nebulizer equipment tubing and masks related to dating and changing as ordered.<br><br>- Administrator, Director of Nursing Services and Assistant Director of Nursing Services will audit all nebulizer equipment in use weekly for four weeks and will check 50% of equipment in use weekly for two additional months to ensure compliance. Results of audits will be taken to center Quality Assurance Performance Improvement committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |

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|---|---|---|---|
| | 255109 | A. BUILDING _____ B. WING _____ | 02/06/2020 |

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

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|---|---|---|---|---|
| F 695 | Continued From page 24<br>Resident #99, dated 02/04/2020, revealed an order for Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/milliliter (MG/ML) 1 inhalation - inhale orally as needed for congestion - 3 ml inhalation for nebulizer treatment. There was not an order to indicate how often nebulizer equipment should be changed and/or stored. | F 695 | | |

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|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/04/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **DIVERSICARE OF SOUTHAVEN** | **1730 DORCHESTER DR**<br>**SOUTHAVEN, MS 38671** |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ... | K 000 | | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to properly maintain the fire alarm system in accordance to NFPA 72. Based on record review, the facility failed to properly perform as per NFPA 72 section 14.4.5.3.2. The deficient practice affected the entire facility on day of survey.<br><br>Findings include:<br><br>During document review on 2/4/2020 at 2:15 PM, the facility could not provide documentation showing the sensitivity testing of the fire alarm system in the last two (2) alternate calendar years (2017 and 2019). Sensitivity testing of the fire alarm system shall be conducted every alternate year. | K 345 | - Center had a full inspection of the Fire Alarm system including sensitivity testing on 12/30/2019, but vendor omitted the smoke detector sensitivity testing documentation. Vendor contacted on 3/6/2020 to provide documentation or schedule smoke detector sensitivity testing on or before 3/13/2020.<br><br>- Smoke detector sensitivity and the failure to provide smoke sensitivity testing and the subsequent documentation has the potential to affect all residents in the center.<br>- Center Administrator provided education to the Maintenance Director on 2/10/2020 on the requirement for smoke detector | 3/10/20 |

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

Electronically Signed | 03/06/2020

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/04/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIVERSICARE OF SOUTHAVEN** | **1730 DORCHESTER DR**<br>**SOUTHAVEN, MS 38671** |

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|---|---|---|---|---|
| K 345 | Continued From page 1 | K 345 | sensitivity testing to be conducted every other year. The training included that the required documentation for the alternate year smoke detector sensitivity testing shall be maintained at an approved, secure location and be available for review at any time.<br><br>- A reminder for the task to have smoke device sensitivity testing performed every two years and the accompanying documentation will be set up in a computerized maintenance management system (TELS) to automatically notify the administrator and maintenance manager of a due date. Center administrator will audit Life Safety records monthly for 3 months to ensure documentation requirement compliance and documentation availability. Results of audit will be taken to center Quality Assurance Performance Improvement committee meeting. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |
| K 712 SS=D | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded | K 712 | | 3/10/20 |

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|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **02/04/2020** |

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

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| K 712 | Continued From page 2<br>announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. The deficient practice affected the entire facility on day of survey.<br><br>Findings include:<br><br>During document review on 2/4/2020 at 2:20 PM, the facility could not provide complete documentation of a fire drills conducted on any work shifts during the last calendar year of 2019. | K 712 | - Center conducted fire drills on all shifts on 2/28/2020 and 2/29/2020. Sign-in sheets for participating team members and the signed drill reports were uploaded to the TELS system as required by center policy.<br><br>- All shifts were covered by the fire drills conducted on 2/28/2020 and 2/29/2020. All residents have the potential to be affected by the deficiency in fire drills.<br><br>- Center Administrator provided education to the Maintenance Director on 2/10/2020 on the requirement to conduct fire drills for the center to include the maintaining of sign-in sheets for participating team members and signed drill reports from the person conducting the drill. Fire Drills will be held at expected and unexpected times under varying conditions and at least quarterly for each shift. Fire drill documentation shall be maintained at an approved, secure location.<br><br>- The fire drill requirement to conduct and provide accompanying documentation will be set up in a computerized maintenance management system (TELS) to automatically notify the administrator and maintenance manager of a due date. Center administrator will audit fire drill completion for 100% of fire drills conducted for all shifts for six months to | |

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|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/04/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIVERSICARE OF SOUTHAVEN** | **1730 DORCHESTER DR**<br>**SOUTHAVEN, MS 38671** |

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|---|---|---|---|---|
| K 712 | Continued From page 3 | K 712 | ensure compliance with the standard. Results of audits will be taken to center Quality Assurance Performance Improvement committee meeting for six months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented.. | |
| K 918 SS=D | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and | K 918 | | 3/10/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/04/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIVERSICARE OF SOUTHAVEN** | **1730 DORCHESTER DR**<br>**SOUTHAVEN, MS 38671** |

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| K 918 | Continued From page 4<br>circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. The deficient practice affected the entire facility on day of survey.<br><br>Findings include:<br><br>During document review on 2/4/2020 at 2:12 PM, the facility could not provide documentation showing the weekly inspections and monthly load tests for the generator for the months March, April, July and August of 2019. | K 918 | - Center conducted all weekly emergency generator tests and monthly full load test for January and February, 2020. All tests are being documented in the TELS system as outlined by center policy.<br><br>- All residents have the potential to be affected by the deficient practice of not weekly exercising the generator and loading the generator monthly and providing associated documentation logs.<br><br>- Center Administrator provided education to the Maintenance Director on 2/10/2020 on the requirement to conduct weekly generator exercising and monthly generator load tests according to NFPA 110 requirements and the subsequent documentation/record keeping. Weekly, monthly and annual generator logs and preventive maintenance records and documentation shall be maintained at an approved, secure location.<br><br>- Center administrator will audit weekly generator tests and monthly load tests in TELS for three months to ensure compliance with the standard. Results of audits will be taken to center Quality Assurance Performance Improvement | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255109 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/04/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIVERSICARE OF SOUTHAVEN** | **1730 DORCHESTER DR**<br>**SOUTHAVEN, MS 38671** |

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|---|---|---|---|---|
| K 918 | Continued From page 5 | K 918 | committee meeting for three months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255109 | A. BUILDING **02 - BEVERLY HEALTHCARE-SOUTHAVEN** B. WING _____ | **02/04/2020** |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).<br><br>There were no LSC deficiencies cited during this survey. | K 000 | | |

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

Electronically Signed | 03/06/2020

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.

| 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 _____ | 02/04/2020 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>* EMERGENCY PREPAREDNESS *<br><br>Survey conducted on 2/4/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements.<br><br>No deficiencies were identified. | E 000 | | |

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

Electronically Signed | 03/06/2020

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.