STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. BUILDING _____ B. WING _____	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TYLERTOWN	200 MEDICAL CIRCLE TYLERTOWN, MS 39667

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification from 12/15/19 through 12/18/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F641, F657, F695, F759, and F812. At the time of the survey, the facility had a census of 42 residents, and held a license for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to the use of a Continuous Positive Airway Pressure (CPAP) machine, Resident #31, for one (1) of 14 resident MDS assessments reviewed. Findings include: A review of the facility's "MDS Coding" policy, dated June 2017, revealed: MDS coding is completed by utilizing Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual and the State of Mississippi Division of Medicaid Case Mix Index (CMI). A review of the CMS RAI Version 3.0 Manual,	F 641	1) The Registered Nurse Assessment Coordinator (RNAC) modified Minimum Data Set (MDS) identified in error to correctly code Continuous Positive Airway Pressure (CPAP) accurately. Completed 12/20/2019. 2) All Resident's with CPAP have the potential to be affective by the deficient practice. The RNAC to audit 100% of records for coding CPAP accurately. For any inaccuracy in CPAP coding found on audit implement modification of MDS. 1/3/2020 3)The RNAC will have second person (Director of Nursing Services (DNS) or Health Information Coordinator (HIMC)) to	1/17/20

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

Electronically Signed | 01/17/2020

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F 641	Continued From page 1 Chapter 1, revealed an accurate assessment required collecting information from multiple sources, some of which are mandated by regulations. Resident #31 A review of the Admission MDS for Resident #31, with an Assessment Reference Date (ARD) of 8/26/19, revealed Special Treatments and Programs (Section O), was not coded for CPAP usage. Observations on 12/15/19, 12/16/19, and 12/17/19, revealed Resident #31 had a CPAP machine on her night stand. On 12/16/19 at 8:38 AM, an interview with Resident #31, revealed she used her CPAP machine every night. A review of Resident #31's physician orders, dated 9/26/17, documented C-PAP at bedtime every evening shift. On 12/17/19 at 3:45 PM, an interview with Registered Nurse (RN)/MDS Nurse #1, revealed Resident #31 did use the CPAP machine. RN #1 confirmed, Resident #31's MDS was coded inaccurately. RN #1 stated she used the Resident Assessment Instrument (RAI) Manual as a guideline to complete the MDS. On 12/18/19 at 9:26 AM, an interview with the Director of Nurses (DON), revealed she would expect the MDS Nurse to "Mark the correct box" on the MDS assessment. A review of the facility's Face Sheet, revealed the	F 641	review coding of CPAP coding prior to completion and submission of the record for the next 30 days starting 1/1/20 and ending 1/30/20. The Clinical Reimbursement Specialist (CRS) provided education to RNACs on coding CPAP on MDS. This was completed by 12/30/2019. 4) Administrator/DNS/HIMC will audit 100% of MDSs for accurate CPAP coding weekly x four weeks then sample of 10% monthly x two months. Finding of this audit will be reviewed in Quality Assessment Performance Improvement(QAPI) monthly where extensions to plan will be made based on center compliance. Audit schedule is weekly starting 1/3/2020 till 3/20/2020	

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F 641	Continued From page 2 facility admitted Resident #31, on 9/25/17, with a diagnosis of Sleep Apnea.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to revise the comprehensive care plans for two (2) of 14 resident care plans reviewed, Residents #31 and	F 657	1)The Registered Nurse Assessment Coordinator (RNAC) on 12/19/2019 modified care plan to address self-use of Continuous Positive Airway Pressure	1/17/20

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F 657	Continued From page 3 #40. Findings include: A review of the facility's "Care Plans" policy, dated 6/17, revealed: The care plans would be developed for all 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. Resident #40 Review of Resident #40's comprehensive care plan related to use of psychotropic medications, initiated 3/18/19, revealed, the resident was to attend Intensive Outpatient Program (IOP) weekly on Monday, Wednesday and Friday. Review of Resident #40's physician's orders, dated 8/26/19, revealed a discontinue order for attending IOP. During an interview with Licensed Practical Nurse (LPN) #1, on 12/16/19 at 2:22 PM, she stated Resident #40 had graduated and no longer attends IOP. On 12/17/19 at 3:43 PM, an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) Nurse, confirmed Resident #40 was no longer on IOP. RN #1 stated the resident had "graduated" the program. RN #1 stated the care plan was not correct because it was not updated when Resident #40 completed IOP. On 12/18/19 at 9:43 AM, an interview with the	F 657	(CPAP) on Resident #31. The RNAC on 12/19/2019 modified care plan to remove Intensive Outpatient Program Intellectual Disability/Developmental Disability (ID/DD) services that had been discontinued on Resident #40. 2)The RNAC/Clinical team/Interdisciplinary team to audit 100% of care plans of current residents to ensure care plan addresses correct self-use of CPAP and any outpatient ID/DD type services. Audits began 12/30/2019. For any care plans found deficient, updates of plan of care will be completed immediately. 3)The IDT will review care plans weekly beginning on 1/7/2020 per schedule to ensure care plan reflects resident centered care as ongoing action. Clinical Reimbursement Specialist (CRS) completed inservice/education on 12/30/2019. 4) Administrator/Director of Nursing services/Health Information Coordinator will audit 100% of care plans completed each week for two weeks then 25% for two weeks then audit 10% monthly for two months to identify any deficiency in resident centered care. Findings of this audit will be reviewed in QAPI monthly where extensions to plan will be made based on center compliance. Audits will begin on 1/7/2020.	

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F 657	Continued From page 4	F 657		

Director of Nurses (DON), revealed she was aware of the incorrect care plan for Resident #40. The DON stated the staff met daily to put new orders in the computer. The DON stated the intervention should have been removed the day the order was discontinued. The DON stated the care plan was a guidance for the staff to take care of the resident, and it should be updated timely.

Resident #31

A review of Resident #31's comprehensive care plan related to diagnosis of Congestive Heart Failure (CHF), initiated 10/3/17, revealed an intervention for Continuous Positive Airway Pressure (CPAP) nightly and clean reservoir as ordered. The care plan did not indicate any interventions related to storage of the CPAP mask.

An observation on 12/15/19 at 2:20 PM, revealed Resident #31's CPAP mask lying on her bed unbagged.

On 12/15/19 at 4:43 PM, an observation revealed Resident #31's CPAP mask lying on her bed, unbagged.

An observation on 12/16/19 at 8:35 AM, revealed Resident #31's CPAP mask to be lying on her bed and unbagged.

During an interview, on 12/16/19 at 8:38 AM, Resident #31 revealed she used her CPAP machine every night.

An observation on 12/17/19 at 10:00 AM, revealed Resident #31's CPAP mask was lying on her night stand unbagged.

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F 657	Continued From page 5 During an interview, on 12/17/19 at 3:45 PM, RN #1 stated she would expect the staff to review and follow the comprehensive care plan once it is revised and completed. On 12/18/19 at 9:29 AM, an interview with the DON, revealed the care plan was a guide for the staff to care for the residents. The DON stated the staff should read it and do what the care plan tells them to do.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store Resident #31's Continuous Positive Airway Pressure (CPAP) mask in a manner to prevent cross contamination for one (1) of two (2) residents reviewed for respiratory care. Findings include: A review of the facility's "Infection Control" policy, dated June 2017 revealed, Bi-level Positive Airway Pressure (Bi-PAP) and Continuous Positive Airway Pressure (CPAP) will be maintained including cleaning per the	F 695	1)Resident #31's Continuous Positive Airway Pressure (CPAP) was cleaned and stored per manufacturer guidelines at time of notification,12/17/2019, by Nursing Staff. On 12/17/2019, Nursing Staff educated Resident regarding proper storage of CPAP. 2) All residents with CPAP's were identified. All CPAPs were cleaned and stored per manufacturer guidelines on 12/17/2019 by Nursing Staff. 3) Nurses and Nurse Aids educated on	1/17/20

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F 695	Continued From page 6 manufactured guidelines of the product. Review of an untitled and undated document, provided by the facility, revealed instructions on CPAP hygiene. Mask and tubing need a full bath once a week to keep it free of dust, bacteria and germs. An observation, on 12/15/19 at 2:20 PM, revealed Resident #31's CPAP mask lying on her bed unbagged. On 12/15/19 at 4:43 PM, an observation revealed Resident #31's CPAP mask lying on her bed, unbagged. An observation on 12/16/19 at 8:35 AM, revealed Resident #31's CPAP mask to be lying on her bed and unbagged. During an interview, on 12/16/19 at 8:38 AM, Resident #31 revealed she used her CPAP machine every night. An observation, on 12/17/19 at 10:00 AM, revealed Resident #31's CPAP mask lying on her night stand unbagged. During an interview, on 12/17/19 at 10:41 AM, the Assistant Director of Nurses (ADON) revealed, Resident #31's CPAP mask should be stored in a clean plastic bag. On 12/17/19 at 1:43 PM, an interview with the Director of Nurses (DON), confirmed the CPAP mask should be stored in a plastic bag because of infection control issues. A review of the facility's Face Sheet, revealed the	F 695	importance of proper storage of CPAP masks and Nurses were educated on manufacturer's recommendations for proper cleaning of CPAP done by Assistant Director Nursing Services (ADNS)/Director of Clinical Education (DCE) implemented on 12/20/2019 to be completed by 1/17/2020. 4)All CPAP machines will have their CPAP's cleaned and storage per manufacturer guidelines. Audits by Director Nursing Services/ADNS will be done daily x five days a week x four weeks. Audits started 12/23/2019 to be completed 1/17/2020. All adverse findings will be taken to Quality Assurance and Performance Improvement.	

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F 695	Continued From page 7 facility admitted Resident #31 on 9/25/17 with a diagnosis of Sleep Apnea.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to administer medications in a manner to prevent medication errors for one (1) of five (5) residents observed for medication pass administration, Resident #16. The facility had a medication error rate of 6.45%. Findings include: A review of the facility's "Medication Administration" policy, dated June 2017, revealed, the facility follows (Name of Pharmacy)/Pharmacy Consultant, policies and procedures for medication administration. A review of the (Name of Pharmacy)/Pharmacy Consultant "General Dose Preparation and Medication Administration" policy, dated 12/01/07, revealed: The facility should verify that the medication name and dose are correct. The pharmacy should be contacted to provide the correct dose. The facility should verify each time a medication is administered that it is at the correct dose.	F 759	1) On 12/16/2019, Resident #16 was assessed with no adverse effects noted. A pain assessment was completed on Resident #16 on 1/16/2019, with no concerns identified. 2)Director Nursing Services (DNS)began audit on 12/16/2019 and completed the audit on 12/18/2019 to identify all residents with order for Tylenol Arthritis Extended Release. No other residents have an order for Tylenol Arthritis Extended Release only Resident #16. Health Information Coordinator (HIMC) purchased Tylenol Arthritis Extended Release on 12/16/2019 and placed on medication cart #2. 3 Licensed Practical Nurse (LPN) LPN#2 was immediately educated by Assistant Director Nursing Services (ADNS) on 12/17/2019 of five rights of medication administration. Beginning 12/17/2019, ADNS provided education to all nursing staff on the five rights of medication administration.	1/17/20

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F 759	Continued From page 8 A record review of Resident #16 physician's orders revealed, an order dated 9/25/19, for Tylenol (Acetaminophen) Eight (8) Hour Arthritis Pain Tablet Extended Release (ER) 650 milligrams (MG), give one (1) tablet by mouth two (2) times a day related to Other Chronic Pain. A review of Resident #16's December 2019, Electronic Medication Administration Record (EMAR) revealed an order for Tylenol 8 Hour Arthritis Pain Tablet Extended Release 650 MG, give one tablet by mouth two times a day related to other chronic pain. An observation on 12/16/19 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #2 retrieved a bottle labeled Acetaminophen 325 MG tablets from the medication cart, poured 2 tablets into a medication cup, and gave them to Resident #16 along with resident's other medications. During an interview, on 12/16/19 at 11:37 AM, LPN #2 confirmed she had given 2 of the Tylenol 325 MG tablets to Resident #16. LPN #2 stated she gave 2 of the 325 MG Regular Strength Tylenol to equal the 650 MG dose. LPN #2 also stated she was thinking the Tylenol 325 MG Regular Strength and the Tylenol 8 hour Arthritis Pain Tablet Extended Release 650 MG (Acetaminophen ER) were the same as long as they were not enteric coated tablets. An interview on 12/16/19 at 11:47 AM, with the Consultant Pharmacist revealed, the Regular Strength 325 mg tablet of Tylenol was not an extended release tablet. The Consultant Pharmacist stated if the medication bottle did not have extended release, then the medication was not extended release.	F 759	4)The Director Nursing Services(DNS)/ADNS/weekend Registered Nurse Supervisor to conduct audits beginning on 12/17/2019, 5x a week for 1 week, 3x a week for 2 weeks, then weekly for 5 weeks to assure Tylenol Arthritis Extended Release is available. Any adverse findings will be taken to Quality Assurance Performance and Improvement. If adverse finding is identified facility will immediately put plan of correction in place.	

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F 759	Continued From page 9 During an interview, on 12/17/19 at 1:36 PM, the Director of Nurses (DON) stated, if LPN #2 looked on her medication cart and saw she did not have the correct dosage of the medication, she should have checked the supply room. The DON stated if the medication was unavailable, the nurse would need to call the physician and get the medication order changed. The DON stated the nurse should give the medication as ordered. A review of the facility's Face Sheet revealed, the facility admitted Resident #16 on 9/19/17, with a diagnosis of Other Chronic Pain.	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		1/17/20

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F 812	Continued From page 10 by: Based on observation, staff interview, facility policy review, the facility failed to prevent cross contamination of milk products as evidenced by failure to separate expired milk from milk that was in date, for one (1) of three (3) kitchen observations. Findings include: Review of the facility's "Food Storage: Cold Foods" policy, with a revision date of 4/2018, revealed: All foods would be stored, labeled, dated, and arranged in a manner to prevent cross contamination. An observation during the initial tour, on 12/15/19 at 1:13 PM, with Dietary Staff (DS) #1, revealed four (4) 8 ounce (oz) cartons of 2% milk, with an expiration date of 12/13/19, in the milk refrigerator. The expired milk was mixed in with the milk that was in date, and not separated. On 12/15/19 at 1:18 PM, an interview with DS #1, revealed she stated the milk delivery person was suppose to check and remove the expired milk. DS #1 revealed she did not know why the expired milk was mixed with the fresh milk. DS #1 confirmed the expiration date on the 4 cartons of milk was 12/13/19. On 12/15/19 at 4:14 PM, an interview with Dietary Manager (DM), confirmed the milk was expired. The DM revealed she moved the expired milk to another area of the milk refrigerator, and placed a sign of "do not use". The DM stated the milk delivery person came once a week, on Tuesday, and would swap them out.	F 812	1)On 12/15/2019, Expired cartons of milk put in crate and separated from non expired milk. On 12/15/2019,Signed placed on crate "Expired Do Not Use". Expired cartons picked up on 12/24/2019 by Brown's Dairy. The Administrator in-serviced dietary staff on 12/16/2019 on Health Care Service Group policy #19 Cold Food Storage due to expired milk in storage area. 2) All Residents have the potential to be affected by the deficient practice . Milk expiration audit started on 12/16/2019 and was completed on 12/16/2019. Audit will be performed by the Dining Service Director (DSD). 3)Beginning 12/16/2019, The DSD or the morning cook to perform daily check list to assure the facility has no expired milk. 4)The DSD will conduct milk expiration audits beginning 12/16/2019, 5x for 1 week, 3x a week for 2 weeks, then weekly for 5 weeks. Any adverse findings will be take to Quality Assurance and Performance Improvement.	

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F 812	Continued From page 11 On 12/17/19 at 1:18 PM, an interview with the DM, revealed the responsibility of checking the dates on the milk cartons between the milk deliveries was with the dietary aides. The DM stated the expectation was for the expired milk to be removed and separated from the rest of the milk, with a label placed of "do not use" until the next milk delivery. The DM stated the concern was related to cross contamination.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TYLERTOWN	**200 MEDICAL CIRCLE** **TYLERTOWN, MS 39667**

(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). 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 | 01/17/2020

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
	255100	A. BUILDING _____ B. WING _____	12/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TYLERTOWN	200 MEDICAL CIRCLE TYLERTOWN, MS 39667

(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 ********** Survey conducted on 12/15/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 01/17/2020

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