STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	A. BUILDING _____ B. WING _____	01/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 1/8/19 through 1/10/19. 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 F 656, F 758, and F 880. At the time of the survey, the census was 109 and the facility held a license for 120 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		2/1/19

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy, the facility failed to develop and implement the comprehensive care plan to ensure infection control techniques were provided, related to wound care, for one (1) of 25 resident care plans reviewed. Resident #85. Findings include: A review of the facility's policy titled "Care Plans", with an effective date of June 2017, revealed care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) Manual guidelines. A review of the RAI Version 3.0 Manual dated October 2018 chapter 4 page 4-3, revealed: It is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.	F 656	1. Resident #85's care plan was reviewed by Minimum Data Set Nurse on January 9, 2019 and revised to reflect wound care that adheres to infection control practices to promote healing. 2. All care plans of residents with wounds have the potential to be affected by the alleged deficient practice. 3. All residents with wounds, had care plans reviewed by MDS nurse on January 9, 2019, to assure wound care plan was reflective of infection control guidelines to promote healing. Care plans will be reviewed and revised as needed at Daily Start up by the interdisciplinary team. 4. Minimum Data Set Nurse or Director of Nursing Services or Assistant Director of Nursing Services will conduct care plan	

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F 656	Continued From page 2 The comprehensive care plan with an onset date of 12/8/16, included interventions for pressure ulcer care and treatments as ordered to Resident #85's right hip ulcer. The care plan did not have interventions to follow infection control techniques/guidelines. Observation on 1/9/19 at 11:12 AM, revealed Licensed Practical Nurse (LPN) #1 performed wound care on Resident #85. LPN #1 washed her hands, applied clean gloves, removed Resident #85's soiled dressing to his right hip, and without washing hands/changing gloves, LPN #1 cleaned Resident #85's right hip ulcer using the same gloved hands she used to remove Resident #85's dressing to his right hip. LPN #1 then removed her gloves, used Alcohol Based Hand Gel (ABHG), applied clean gloves, and placed clean dressings to Resident #85's wound. Resident #85's wound bed observed to be covered with black eschar tissue, are has no odor, drainage, bleeding or signs of infection noted. On 1/10/19 at 3:00 PM an interview with Registered Nurse (RN) #2 revealed LPN #1 should have removed her gloves, washed her hands, and applied clean gloves before cleaning the wound, because that is an infection control issue. On 1/10/19 at 2:32 PM, an interview with RN #1 revealed she would expect the staff to follow the comprehensive care plans (to provide care as ordered). On 1/10/18 at 2:45 PM an interview with the Director of Nurses (DON) revealed, she would expect the staff to follow the comprehensive care	F 656	audits for residents with wounds weekly x 8 week's and monthly thereafter. All audits will be brought to monthly QAPI for review and follow up as needed.	

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F 656	Continued From page 3 plan (to provide treatment as ordered).	F 656		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		2/1/19

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F 758	Continued From page 4 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to provide a stop date for psychotropic medication ordered as needed for one (1) of six (6) unnecessary medication reviews. Resident #44. Findings include: Review of the facility policy revealed that gradual dose reductions (GDRs) are a standard practice in nursing homes. Nursing home regulations require that certain medications affecting the brain be assessed for a GDR at regular intervals. Gradually reducing the dose of medications is a way for the quality care team to determine if someone is taking the lowest effective dose or to determine whether the continued use of the medication is still needed. By using the lowest effective dose of a medication, the resident will be at less risk for side effects. Record review revealed an order for Ativan 1 milligram (mg) by mouth (po) every six (6) hours as needed for anxiety, ordered on 6/29/18, with a start date of 06/30/18. The order failed to include	F 758	1. Resident #44 had medications reviewed on January 10, 2019 by Nurse Practitioner. Ativan order was discontinued on 1/10/19. 2. All residents with antipsychotics or anxiolytics have the potential to be affected by the alleged deficient practice. 3. All residents with antipsychotics or anxiolytics had orders reviewed and stop dates after 14 days put in, if not already in place. Director of Nursing Services /Assistant Director of Nursing services will review all antipsychotic and anxiolytic orders at Daily Clinical Start up. 14 day stop dates will be put into place for review, reduction, or discontinuation if possible. 4. Coordination and discussion will be with pharmacy consultant and physician for review, reduction, and discontinuation, if possible by February 10, 2019. The Director of Nursing Services or Assistant	

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F 758	Continued From page 5 an end/stop date. Review of the pharmacy consultation report, dated 8/28/18, informed Resident #44's physician of the Centers for Medicare and Medicaid Services (CMS) requirements concerning stop dates for psychotropic/anxiolytic medications. Record review revealed the physician declined the recommendation due to panic attacks, but did not re-order the medication with a stop date. Record review of the Medication Administration Record (MAR), revealed Resident #44 continued to receive Ativan 1 mg po every six (6) hours as needed past the required 14 day limit set by CMS. There was no documentation, by the physician, of the rationale for the extended period of time the medication was administered and the intended duration for the as needed (PRN) order. On 01/10/19 at 11:52 AM, an interview, with the director of Nursing (DON) revealed she had just recently in the past few months learned about the regulation concerning stop dates for antipsychotic and psychotropic medications. The DON stated their consultant Pharmacist is working with them on this issue, but they are obviously going to need to include the doctors in the education concerning the CMS requirements.	F 758	Director of Nursing Services will review and audit orders for antipsychotic and anxiolytic orders weekly x 8 weeks and then monthly thereafter. Audits will be brought to monthly QAPI for review and follow up as needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		2/1/19

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F 880	Continued From page 6 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 7 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, facility statements and facility Infection Control Guide, the facility failed to provide wound care in a manner to prevent the possible spread of infection for one (1) of four (4) resident with wounds. Resident #85. Findings include: A review of the facility's statement, signed by the Administrator and dated 1/9/19, revealed: The facility does not have a policy for wound care and uses the Wound Assessment Guide to implement resident care. A review of the facility's statement, signed and dated by the Administrator on 1/9/19, revealed: The facility does not have a policy for infection	F 880	1. Resident #85's wound was cleaned on January 9, 2019, by LPN 1 using proper infection control technique to aid in wound healing. Director of Clinical Education (DCE) educated LPN 1 regarding infection control techniques and proper wound care. Specifically with regard to changing gloves between removing bandages and placing new bandages on wound. DCE then observed LPN 1 performing wound care using proper infection control techniques. 2. All residents with wounds have the potential to be affected by the alleged deficient practice. 3. Education for LPN 1 wound care	

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F 880	Continued From page 8 control and uses the Infection Control Guide to implement care. The facility's Infection Control Guide indicated, when standard precautions are properly followed and adhered to, they reduce the risk of transmission of infectious agents between patients/residents and team members even when the presence of an infectious agent is unknown or not apparent. A review of Perry and Potter Eighth Edition, page 133, revealed: Remove old dressing one layer at a time. Dispose of soiled dressings in waterproof bag. Remove disposable gloves by pulling them inside out, and dispose of them in waterproof bag. Perform hand hygiene. On 1/9/19 at 11:12 AM, LPN #1 performed wound care on Resident #85's right hip. LPN #1 washed her hands, applied clean gloves, removed Resident #85's soiled dressing, then cleaned Resident #85's right hip wound, using the same gloved hands she used to remove the old dressing. LPN #1 then removed her gloves, used Alcohol Based Hand Gel (ABHG), applied clean gloves, and placed a clean dressing to Resident #85's wound. Resident #85's wound bed was observed to be covered with black eschar tissue, and the area had no odor, drainage, bleeding or signs of infection noted. On 1/10/19 at 3:00 PM, an interview with Registered Nurse (RN) #2 revealed training the facility staff on infection control is done on an as needed basis. RN #2 also stated LPN #1 should have removed her gloves, washed her hands, and applied clean gloves before cleaning the wound, because that is an infection control issue.	F 880	nurses by the Director of Clinical Education was immediately completed on January 9, 2019 regarding appropriate infection control techniques when providing wound care. All nurses will be educated on proper wound care technique by 2/10/19. DNS/ADNS/DCE will observe all nurses performing wound care using proper infection control techniques two times per week x 8 weeks then monthly thereafter. 4. Observation information will be brought to monthly QAPI for review and follow up as needed.	

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F 880	Continued From page 9 On 1/10/18 at 2:45 PM an interview with the DON revealed, LPN #1 kept the same gloves on to clean Resident #85's wound that she used to remove the soiled dressing. The DON stated that was an infection control issue. On 1/10/19 at 2:47 PM, the Assistant Director of Nursing (ADON) confirmed the nurse should have removed her gloves, washed her hands, and placed on clean gloves prior to placing the new dressing. The ADON confirmed an issue with infection control.	F 880		

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	255105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) 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 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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. 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 circuits are marked, readily identifiable, and	K 918		2/1/19

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K 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on the review of documentation, the facility failed to properly document records of testing the generator annually as directed by NFPA 99 sections 6.4.4.1.1.3 and 6.4.4.2. This deficient practice had potential of affecting the entire facility on the day of facility survey. Findings include: On 1-10-19 at 11:25 AM, the facility could not produce documentation showing the current 2018 annual testing and service of the generator. The facility last annual test of the generator was documented and performed on 12-28-17. The finding was acknowledged by the Administrator and Maintenance Supervisor during the exit interview on 1-11-19.	K 918	1. Annual generator inspection that was scheduled for January, 2018, occurred 12/28/17. 2. All residents have the potential to be affected. The generator inspection was scheduled and completed on 1/15/19 with no adverse findings. 3. The Generator inspection was completed on 1/15/19. No negative findings reported. See Attached Documents. 4. The Maintenance Director has scheduled the annual generator survey for January, 2020, and will contact generator inspectors 1 week prior to January to confirm inspection date. Any negative findings will be reported to the center QAPI committee.	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 1/10/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 02/01/2019

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.