STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey, at the facility, from 03/02/2020 to 03/05/2020. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited deficient practice at F656 and F695. At the time of the survey, the facility had a census of 115, and held a license for 119 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		4/13/20

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

Electronically Signed | 05/07/2020

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
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 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 review, the facility failed to follow the comprehensive care plan for respiratory care related to storage of respiratory equipment, for two (2) of seven (7) resident care plans reviewed for Respiratory Care; Resident #27 and Resident #72. Findings include: Review of the facility's "Care Plans" policy, 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. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change." Resident #27 Record review of Resident #27's care plan,	F 656	1. Registered Nurse (RN) changed the tubing on affected residents. 100% audit was completed by the Director of Nursing (DNS) and the Assistant Director of Nursing (ADNS)on 3/5/2020 to ensure no other tubing was improperly stored. 2. All residents who were on oxygen were assessed for respiratory issues by the RN charge nurse on each unit on 3/5/2020. Education was conducted by Director of Clinical Education for all direct care team members regarding storage of oxygen tubing when not in use per care plan and was completed 3/13/2020. 3. Room rounds, which include observation of oxygen tube storage, were conducted by department leaders. The Administrator or DNS followed up on these room rounds daily x two (2) weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 656	Continued From page 2 revealed a focused problem for Alteration in Respiratory Status. Interventions included to store nebulizer in plastic bag when not in use. During an observation, on 03/02/2020 at 11:32 AM, Resident #27's nebulizer mask was observed unbagged, lying on top of the nebulizer machine. There was no bag or other protective cover seen in the resident ' s room. An observation, on 03/03/2020 at 10:49 AM, revealed Resident #27's nebulizer mask was lying on top of her nebulizer machine and not in a bag. On 03/04/2020 at 10:05 AM, during an observation, Resident #27's nebulizer mask remained on top of the nebulizer machine and not in a protective cover. During an observation and interview, on 03/04/2020 at 11:48 AM, with Registered Nurse (RN) #1, she confirmed Resident #27's nebulizer mask was lying on top of the nebulizer machine uncovered. During an observation of Resident #27's care plan, with the Director of Nursing (DON), she confirmed Resident #27 had a care plan with an intervention to store the nebulizer mask in a plastic bag when not in use. An interview, on 03/04/2020 at 2:30 PM, with the DON, confirmed Resident #27's care plan was not followed. Resident #72 Record review of Resident #72's care plan revealed a problem which focused on Alteration in	F 656	and then weekly x four (4) weeks. This was completed 4/13/2020. 4. Room round findings will be shared at Daily Connect Meetings. Any adverse oxygen tubing storage findings will be brought monthly to the Centers Quality Assessment Performance Improvement (QAPI) Committee for follow up by the Administrator. This committee consists of the Medical Director, Administrator, DNS and at least three other department managers. This committee will review the audits for additional monitoring and continued improvement and make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 656	Continued From page 3	F 656		

Respiratory Status. Interventions revealed to store nebulizer in plastic bag when not in use.

An observation, on 03/02/2020 at 11:37 AM, revealed, Resident #72's oxygen (O2) cannula and tubing were on the floor behind her wheelchair. The nebulizer mask was not stored in a container to prevent contamination.

During an observation, on 03/03/2020 3:24 PM, Resident #72's oxygen cannula was noted to be draped over the back of her wheelchair, with the cannula lying on her wheelchair seat cushion. Resident #72's nebulizer machine and nebulizer mask was sitting on the overbed table, and not in a bag.

On 03/04/2020 at 11:48 AM, during an observation with RN #1 and LPN #2, revealed, Resident #72's oxygen tubing was draped over the back of her wheelchair, and her handheld nebulizer was on her nebulizer machine uncovered.

During an interview, on 03/04/2020 at 11:52 AM, RN #1 revealed she knew oxygen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor.

An interview, on 03/04/2020 at 11:53 AM, with LPN #2, confirmed that all respiratory equipment should be in bags.

During an interview, on 03/04/2020 at 2:30 PM, the DON confirmed Resident #72's care plan was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 4	F 695		
F 695 SS=E	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, resident interview, staff interview, and policy review, the facility failed to store respiratory equipment in a manner to prevent contamination, for six (6) of seven (7) residents reviewed for respiratory care; Resident #3, Resident #27, Resident #53, Resident #72, Resident #87 and Resident #103. Findings include: Review of the facility's "Policies and Practices-Infection Control" policy, dated, November 1, 2017, revealed, "This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections." Resident #3 During an observation, on 03/02/2020 at 12:24 PM, Resident #3's oxygen tubing revealed, the tubing was not dated or labeled. Resident #3's oxygen tubing was draped across his oxygen concentrator and dangling. There was no	F 695	1. Registered Nurse (RN) changed the tubing on affected residents. 100% audit was completed by the Director of Nursing (DNS) and the Assistant Director of Nursing (ADNS)on 3/5/2020 to ensure no other tubing was improperly stored. The 20 residents who were on oxygen were assessed for respiratory issues by the RN charge nurse on each unit on 3/5/2020. No adverse signs and symptoms were noted. 2. The 20 residents who were on oxygen were assessed for respiratory issues by the RN charge nurse on each unit on 3/5/2020. No adverse signs and symptoms were noted. Education was conducted by Director of Clinical Education for all direct care team members regarding storage of oxygen tubing when not in use and was completed 3/13/2020. 3. Room rounds, which include observation of oxygen tube storage, were	4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 5 evidence of a protective covering for the oxygen tubing in the room. On 03/03/2020 at 9:20 AM, an observation of Resident #3's oxygen tubing, revealed it was draped across his oxygen concentrator and continued to be undated and labeled. Resident #3's oxygen tubing was not in a protective covering. On 03/04/2020 at 11:10 AM, Resident #3's oxygen tubing was noted to be laying across his oxygen concentrator and not in a bag. During an interview, on 03/04/2020 at 11:17 AM, Licensed Practical Nurse (LPN) #1 stated the night shift nurse is responsible for changing out the water, tubing, labeling items and placing them in a plastic bag weekly. LPN #1 confirmed Resident #3's tubing was not dated or in a plastic bag. She stated the oxygen tubing should be placed in a bag for infection control purposes, and that you wouldn't want the tubing touching any contaminated surfaces. Resident #53 On 03/02/20 at 2:54 PM, during an observation, Resident #53's oxygen tubing was noted to be wrapped around her bed rail frame and not in a protective covering. On 03/03/20 at 3:54 PM, an observation of Resident #53's oxygen tubing, revealed it was wrapped around the bed rail frame and uncovered. Resident #103 During an interview and observation, on 03/02/2020 at 10:33 AM, Resident #103's oxygen	F 695	conducted by department leaders. The Administrator or DNS followed up on these room rounds daily x two (2) weeks and then weekly x four (4) weeks. This was completed 4/13/2020. 4. Room round findings will be shared at Daily Connect Meetings. Any adverse oxygen tubing storage findings will be brought by the Administrator monthly to the Centers Quality Assessment Performance Improvement (QAPI) Committee for follow up. This committee consists of the Medical Director, Administrator, DNS and at least three other department managers. This committee will review the audits for additional monitoring and continued improvement and make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 6	F 695		

tubing revealed, the tubing was hooked through the water pitcher handle. Resident #103 stated that she had put it there, so it would stay off the floor. Resident #103 stated, at times, she draped it over her oxygen concentrator.

On 03/03/2020 at 9:00 AM, during an observation, Resident #103's oxygen tubing was observed lying across the oxygen concentrator and was not in a protective cover.

During an interview, on 03/04/2020 at 11:17 AM, LPN #1 stated the night shift nurse was responsible for changing out the water, tubing, labeling items, and placing them in a plastic bag weekly. LPN #1 stated the oxygen tubing should be placed in a bag for infection control, and that you wouldn't want the tubing touching any contaminated surfaces.

On 03/04/2020 at 12:07 PM, an interview with the Director of Nursing (DON), revealed, she stated the facility does not have a policy specific to oxygen tubing and proper storage, but that all tubing and humidified bottles of water are changed weekly on the 11 AM to 7 AM shift and should be dated and labeled. The DON stated the tubing should be stored in a plastic bag for infection control purposes and for safety.

Resident #27

An observation, on 03/02/2020 at 11:32 AM, revealed Resident #27's nebulizer mask was not bagged, and lying on top of the nebulizer machine. No bag or other protective cover was observed in room.

During an observation, on 03/03/2020 at 10:49 AM, Resident #27's nebulizer mask was lying on top of her nebulizer machine and not stored in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 7 bag. An observation, on 03/04/2020 at 10:05 AM, revealed, Resident #27's nebulizer mask remained on top of the nebulizer machine and not in a protective cover. During an observation and interview, on 03/04/2020 at 11:48 AM, with Registered Nurse (RN) #1, she confirmed Resident #27's nebulizer mask was lying on top of the nebulizer machine uncovered. RN #1 revealed, she knew oxygen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. On 03/04/2020 at 11:53 AM, during an interview, LPN #2 confirmed that all respiratory equipment should be in bags. Resident #72 An observation, on 03/02/2020 at 11:37 AM, revealed, Resident #72's oxygen (O2) cannula and tubing was on the floor behind her wheelchair. Resident #72's nebulizer mask was not stored in a container to prevent contamination. During an observation, on 03/03/2020 3:24 PM, Resident #72's oxygen cannula was draped over the back of her wheelchair, with the cannula lying on her wheelchair seat cushion. Resident #72's nebulizer machine and nebulizer mask was sitting on the overbed table and was not in a bag. On 03/04/2020 at 11:48 PM, during an observation, with RN #1 and LPN #2, Resident #72's oxygen tubing was noted to be draped over	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 8	F 695		

the back of her wheelchair, and her handheld nebulizer was on her nebulizer machine uncovered.

During an interview, on 03/04/2020 at 11:52 AM, RN #1 revealed she knew oxygen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor.

During an interview, on 03/04/2020 at 11:53 AM, LPN #2 confirmed that all respiratory equipment should be in bags.

Resident #87

During an observation of Resident #87's room, on 03/02/2020 at 10:40 AM, the resident ' s oxygen cannula and tubing were lying on the bed without being in a storage bag. Resident #87 was not present in the room.

During an interview and observation, on 03/02/2020 at 12:33 PM, Resident #87, stated that he used oxygen most of the time when he was in his room, but does not use it when he leaves his room. Resident #87 stated when he leaves the room, he takes his oxygen off, and places the cannula on the bed. Resident #87 stated he had storage bags in the past, but not lately. Resident #87's oxygen cannula and tubing were observed on the bed, until the resident picked it up to put on.

An observation, on 03/03/2020 at 10:00 AM, revealed Resident #87's oxygen cannula was on bed and no storage bag available. Resident #87 was not in the room.

During an observation on, 03/04/2020 at 8:33 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 695	Continued From page 9 Resident #87 was in the room wearing oxygen. There was no bag for storage at noted at the resident's bedside. During an observation and interview with LPN #2, on 03/04/2020 at 11:30 AM, revealed, Resident #87's oxygen tubing was lying on the bed and no storage bag was noted. Resident #87 was not present in the room. LPN #2 stated the oxygen tubing should be stored in a plastic bag to keep it clean when not in use, and staff should date these bags. LPN #2 confirmed a storage bag was not in the resident's room for use.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	**156 E WALNUT AVE** **EUPORA, MS 39744**

(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 | 05/04/2020

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
	255117	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 03/12/20 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 | 05/04/2020

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.