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 _____	04/17/2019

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 recertification along with a complaint , MS#15765, from 04/14/2019 to 04/17/2019. During the survey, the SA determined that the facility was not in compliance with the requirements of participation with Medicare and Medicaid. The SA did not substantiate MS#15765 for quality of care related to skin impairments, with no citations related to the complaint. The SA cited F657, 658, and F641 during the recertification survey. The census at the time of the survey was 103. The facility held a license for 119 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 record review, staff interview and facility policy review, the facility failed to document correct discharge status on the resident assessment for one (1) of 23 records reviewed, Resident #104. Findings include: Review of the facility's letter-head document, dated and signed by the Administrator on April 16, 2019, revealed that the the facility used the Centers for Medicare & Medicaid Services Long Term Care Facility Resident Assessment Instrument User's Manual , Version 1.14, to complete the Minimum Data Set (MDS).	F 641	1. The Registered Nurse Assessment Coordinator (RNAC) modified the Minimum Data Set (MDS) that was identified in error to correctly code the discharge destination immediately, April 17, 2019, upon discovery. 2. Residents who were discharged from the center had the potential to be affected by the coding error. A 100% audit of discharge assessments was completed on April 18,2019 by RNAC and Assistant Director of Nurses (ADNS) for those discharge assessments completed in the last 90 days to identify any errors in coding discharge destination.	6/19/19

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

Electronically Signed — 06/17/2019

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F 641	Continued From page 1 Record review of Resident #104's discharged MDS Assessment, dated 1/28/19, revealed the resident was discharged to the hospital on 01/28/2019. Record review of Resident #104's Physician Discharge Summary, dated 1/29/19, revealed that Resident #104 was discharged home on 01/28/2019, not the hospital. An interview on 04/16/2019 at 4:04 PM, with the Director of Nursing(DON), revealed Resident #104 was discharged home on 01/28/2019. The DON confirmed that the MDS Assessment was inaccurate with documentation that Resident #104 was discharged to the hospital. An interview with the Registered Nurse Assessment Coordinator, RN #1, on 04/16/2019 at 4:30 PM, confirmed that the MDS Assessment for Resident #104's discharge was inaccurate, as the MDS documented the resident was discharged to the hospital, when in fact he was discharged home. RN #1 stated that it was the responsibility of the Registered Nurse Assessment Coordinator to confirm accuracy of the completed MDS Assessment.	F 641	For any inaccuracy in discharge destination found on audit the MDS was modified. 3. The RNAC will have a second person (partner RNAC) to review coding of discharge assessments prior to completion and submission of the record. The RNAC and partner RNAC were in-serviced on 4/17/19 on proper coding of the MDS. 4. The Administrator (Admin) or Director of Nurses (DNS) will audit 100% of discharge assessments weekly beginning April 17, 2019 times four weeks then 50% of discharge assessments weekly times 4 weeks to identify any inaccuracy in discharge destination coding to be completed 6/19/19. Findings of this audit will be reviewed in Quality Assurance Performance Improvement (QAPI) monthly where extension to plan will be made based on the center's compliance.	
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--	F 657		6/19/19

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F 657	Continued From page 2 (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 observation, staff interview and facility policy review, the facility failed to revise the care plan for discontinuation of medication for one (1) of 23 comprehensive care plans reviewed, Resident #75, and; failed to implement the comprehensive care plan to provide the medication as ordered for one (1) of 23 comprehensive care plans reviewed, Resident #12. Findings include: Review of a facility letter-head document, signed by the Administrator, dated 4/17/19, revealed the facility had no specific policy addressing updating/revision of the care plan and revealed the facility used the Medicare and Medicaid	F 657	1. Resident #75 identified with intervention for antipsychotic medication that is no longer ordered. The Registered Nurse Assessment Coordinator (RNAC) resolved the intervention from the care plan immediately on April 19, 2019. Resident #12 was not affected negatively by medication. The physician and responsible party were notified by the licensed practical nurse. Accurate medication was obtained for the resident. Resident's care plan was reviewed by the Interdisciplinary team (IDT) to assure it was reflective of the physician's order. This was completed on April 17, 2019	

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F 657	Continued From page 3 Services Long Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0 User's Manual, version 1.14. Resident #75 Record review of Resident #75's care plan, revised 1/17/19, revealed a problem for drug related complications, associated with use of psychotropic medication, related to: Anti-Psychotic medication. The first intervention listed was to administer Seroquel as ordered. Record review of Resident #75's April 2019's Medication record revealed Seroquel 25 milligram (mg) 0.5 tablet was discontinued as of April 9th, 2019. Record review of Resident #75's current April 2019 Physician's Orders revealed no order for Seroquel. On 4/17/19 at 9:00 AM, an interview with the Director of Nursing (DON) revealed the facility has a morning meeting, which includes Minimum Data Set (MDS) staff, Medical Records, Therapy, Nursing Unit Managers, Dietary, Director of Nursing, and Administrator, where all new orders are discussed and should be updated on the computer before leaving the meeting. The DON confirmed she was aware of Resident #75's care plan not being updated with the medication Seroquel being discontinued. The DON revealed the facility was aware of issues with the care plans and they had been working on correcting them. On 4/17/19 at 11:14 AM, an Interview with Registered Nurse (RN) #1, MDS staff, revealed she attends a morning meeting where all new	F 657	2. The RNAC, Director of Nurses (DNS) and Assistant Director of Nurses (ADNS)completed a 100% audit of all resident care plans to ensure accurate reflection of antipsychotic intervention and cream medication interventions. This was completed 4/17/19. For any care plans with interventions that are inactive, the RNAC/IDT promptly removed those interventions and a care plan meeting to review any changes was held. This was completed by 5/1/19. All residents who receive cream medication had the potential to be affected by this deficient practice. All residents receiving cream for medications care plans were reviewed to assure physician orders were reflected. All nurses were educated on the five rights of medication. This was completed by the Director of Clinical Education (DCE)/DNS and ADNS and was completed 4/18/19. 3. The IDT to review discontinued and completed orders and make adjustment to plan of care based on the review daily beginning 4/17/19. Education to be provided by the DCE to IDT regarding removal of inactive interventions from the plan of care. This education was provided on 4/17/19. All nurses will be educated by the DCE on hire and at least annually regarding the five rights of medication. All nurses will have, at least annually, medication pass observation. The IDT will	

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F 657	Continued From page 4 orders are brought by medical records staff and the care plans are updated from that list. RN #1 confirmed Resident #75's care plan should have been revised with the discontinued order for Seroquel, and stated they just missed it. Resident #12 A review of Resident #12's current Care Plan, not dated, revealed the Resident was at risk for pain and pain related symptoms related to generalized pain and Neuropathy. The Care Plan Interventions included to administer pain medications as ordered. A review of Resident #12's Order Summary Report, revealed an order, with a start date of 04/30/2018, for Voltaren Gel one (1) percent (%) (Diclofenac Sodium)-Apply to right knee topically four (4) times a day related to pain. An observation on 04/15/19 at 9:10 AM, during medication pass, revealed Resident #12 had a Medication Administration Record (MAR) entry for Voltaren Gel 1% to the right knee. LPN #1 looked in the treatment cart and stated she would have to go to the medication room to get the medication because it was not in the drawer. LPN #1 went into the medication room and retrieved a tube of Biofreeze and applied the Biofreeze to Resident #12's right knee. An interview on 04/16/19 at 9:49 AM, with LPN #1, confirmed she administered Biofreeze to Resident #12's right knee. LPN #1 stated she didn't think she had any Voltaren Gel. She stated she administered the wrong medication and she should have called the doctor and asked if he would change it.	F 657	review all residents care plans and revise to reflect any new physician orders. 4. The Administrator/DNS will audit 50% of discontinued/completed orders to ensure adjustments were made to care plan weekly for four weeks, then audit of 10% for the following four weeks to start 4/17/19 and to be completed 6/19/19. Results of audit will be reviewed in Quality Assurance Performance Improvement (QAPI) monthly and any necessary audit will be added based on center compliance. DNS/ADNS/DCE will watch medication passes on various nurses until all nurses have been observed at least once using the following schedule: twice per week x eight weeks, then monthly thereafter. All results of med pass observations will be brought to monthly QAPI for follow up as needed. Care plans will be monitored in daily start up by the DNS/ADNS/designee. All monitoring results will be brought to monthly QAPI for follow up and recommendations as needed.	

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F 657	Continued From page 5 An interview with Registered Nurse #2, on 4/17/19 at 1:11 PM, revealed the care plan is driven by the Minimum Data Set (MDS) and physician orders. RN #2 confirmed the care plan instructed the nurses to administer pain medication as ordered and if LPN #1 did not administer the medication that was ordered, she did not follow the care plan. An interview with the DON on 4/17/19 at 1:20 PM, confirmed LPN #1 did not follow the care plan because she used the wrong medication on Resident #12's knee.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the correct medication was used, per physician's orders, for one (1) of 23 residents reviewed, Resident #12. Resident #12 received Biofreeze to the right knee instead of Voltaren Gel, as ordered and available. Findings include: A review of Resident #12's Order Summary Report, revealed an order, with a start date of 04/30/2018, for Voltaren Gel one (1) percent (%)-Apply to right knee topically four (4) times a day related to pain.	F 658	1. The Director of Nursing Services (DNS) assessed Resident #12 on 4/17/19 and noted that they were not affected negatively by medication. The Physician and Responsible Party were notified by the licensed practical nurse. Accurate medication was obtained for resident. This was completed 4/17/19 and was reviewed by the Director of Nurses. 2. All residents receiving topical pain medication had the potential to be affected by this deficient practice. The Director of Clinical Education(DCE)/Director of	6/19/19

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DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

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F 658	Continued From page 6 An observation on 04/15/19 at 9:10 AM, during medication pass, revealed Resident #12 had a Medication Administration Record (MAR) entry for Voltaren Gel 1% to the right knee. LPN #1 looked in the treatment cart and stated she would have to go to the medication room to get the medication because it was not in the drawer. LPN #1 went into the medication room and retrieved a tube of Biofreeze and applied the Biofreeze to Resident #12's right knee. An interview on 04/16/19 at 9:49 AM, with LPN #1, confirmed she administered Biofreeze to Resident #12's right knee. LPN #1 stated she didn't think she had any Voltaren Gel. She stated she administered the wrong medication and she should have called the doctor and asked if he would change it. Review of a Medication Administration Competency Audit, dated 4/3/18, revealed LPN #1 was checked off on the six (6) rights of medication administration, which included the right medication for the right patient. The Audit was signed by LPN #1 on 4/3/18. An observation on 4/16/19 at 9:25 AM, with LPN #2, revealed she administered Voltaren Gel 1% to Resident #12's right knee. An interview with LPN #2 confirmed the Voltaren Gel was in the treatment cart and confirmed the date of receipt was 1/22/19. On 04/16/19 at 09:45 AM, an interview with the Assistant Director of Nursing (ADON) confirmed the Physician order for Resident #12 was for Voltaren Gel 1% to the right knee topically four (4) times a day. The ADON confirmed there was a tube of Biofreeze in the treatment cart labeled	F 658	Nurses(DNS)/Assistant Director of Nurses(ADNS) reviewed medications beginning 4/17/19 to assure accurate cream was available. All nurses were educated by the DCE on the five rights of medication. This was completed 4/18/19. 3. All nurses were educated by the DCE on the five rights of medication. This was completed 4/18/19. All nurses will be educated, by the DCE, at least annually regarding the five rights of medication. All nurses will have at least annually medication pass observation by the DCE. 4. DNS/ADNS/DCE will watch medication passes beginning 4/17/19 on various nurses until all nurses have been observed at least once using the following schedule: twice per week x eight weeks and then monthly thereafter to be completed by 6/19/19. All results of med pass observation will be brought to monthly Quality Assurance Performance Improvement (QAPI) for follow up as needed. The QAPI committee will make recommendations as needed.	

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F 658	Continued From page 7 with Resident #12's name. Interview with the Director of Nursing (DON) at 10:00 AM on 4/16/18, confirmed that LPN #1 made a medication error if she applied the wrong medication to the resident. She stated LPN #1 should have used the medication ordered by the doctor. The tube of Biofreeze, labeled for the resident and placed in the treatment cart, was removed. The DON stated she thought the nurse just get nervous, but this could have been a big issue The DON confirmed all nurses know they should follow the five (5) rights when giving medications, which included the right medication to the right resident.	F 658		

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	255117	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/15/2019**

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

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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 | 06/11/2019

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.

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 4/15/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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