MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41TM	A. BUILDING: _____ B. WING _____	C 10/04/2022

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

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M 000	Initial Comments The State Agency (SA) conducted complaint investigations (CO) MS #19544, CI MS #18877 and CI MS #19538 at the facility from 9/27/22 through 10/4/22. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA substantiated the complaint for Resident Rights related to privacy, Pressure Wounds related to care received, and Accidents related to a fall and medications left at bedside and cited M500, M615, and M640. The census at the time of the survey was 101 and the facility held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		11/18/22

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M 500	Continued From page 1 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

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M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	On 9/27/2022, the Administrator initiated	

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M 500	Continued From page 4 Based on resident and staff interviews, record review, and facility policy review, the facility failed to protect the resident from misappropriation of resident's funds for one (1) or three (3) residents reviewed for misappropriation. Resident #6. Findings include: Record review of facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy", dated January 2019, revealed, "Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment, and involuntary seclusion) in accordance with Federal and State Laws." Policy also revealed, "Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the residents consent." An interview and observation of Resident #6 on 9/27/22 at 2:55 PM, revealed he received his stimulus check into his account at the facility, but then it was taken out and he would like to get his money back into his account. Resident #6 was in his room sitting in his wheelchair and was going through his financial documents verifying his stimulus check being deposited and withdrawals on his account. An interview with the Business Office Manager (BOM) on 9/28/22 at 4:20 PM, revealed she has only been in her position for a few months and was not working in this position when the stimulus check was deposited or removed and she is unsure what happened with his money. She also	M 500	an investigation of Resident #6 trust account balance. Stimulus check was deposited into trust account April 2021 and subsequently used toward repayment of back balances without the resident's consent. On 9/30/2022, the facility credited the full amount of the stimulus back to Resident #6 account. All residents with a trust account have the potential to be affected. Beginning 10/5/2022, an audit of resident accounts was conducted by the Regional Business Office Manager with no negative findings. On 10/05/2022, Administrator in-serviced Business Offce staff regarding management of resident trust fund accounts. On 10/05/2022, Administrator in-serviced staff regarding Abuse, Neglect, and Misappropriation. The Administrator or Regional Business Office Manager began weekly audits on 10/10/2022 of Trust Account balances for four weeks, then monthly for two months. Findings of the audit were brought to QA 10/28/2022 and will be brought to the Quality Assurance and Performance Improvement committee for review and revision if necessary for three months.	

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stated she is unsure how to pull the financial log for the resident. She contacted the Regional Business Office Manager to clarify this issue.

A phone interview with the Regional Business Office Manager on 9/28/22 at 4:25 PM, revealed Resident #6 had a deposit into his account of the stimulus check in April 2021. He stated this resident came into facility in January 2020 receiving skilled services and these continued until Mar 7, 2020. Since Resident #6 was receiving skilled services, his care was paid at 100% by Medicare and the Medicaid coinsurance once he was accepted on Medicaid in March. He stated at that time, the resident's check was not being received by the facility and this continued until October 2020, when the resident's check was received and put into his account for his monthly care. He stated he is uncertain where his Social Security check was going prior to October 2020, but it was not coming to facility, therefore, the cost being charged to resident was $2,357.62 monthly, and reached a balance of $16,299. He stated from what he can tell by the Resident Fund Management Service data, the stimulus check was deposited into the resident's account and then was being used to go towards the resident's balance and it looks like it was taken out in small increments as care costs. He stated the money from the stimulus check belonged to the resident and should not have been used to pay on his balance unless the resident agreed and consented to this and his money would be returned to his account.

An interview with the Administrator on 9/30/22 at 2:15 PM, revealed the stimulus check belonged to the resident and should not have been used by the facility without the consent of the resident and the resident can not be forced to use his stimulus

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M 500	Continued From page 6 money to pay on the balance of his account. The Administrator confirmed the facility misappropriated Resident #6's stimulus money by not obtaining consent and agreement from the resident prior to the money being applied to the balance of the resident's account. Record review of Resident #6's Resident Fund Management Service - Resident Statement Landscape, provided by the Business Office Manager revealed the resident's $1400.00 stimulus check was deposited into Resident #6's account on 04/7/21. Record review of Resident #6's face sheet revealed he was admitted to the facility on 01/27/20 with diagnoses which included Chronic Diastolic Congestive Heart Failure, Hypertension, and Acute Kidney Failure. Record review of the quarterly Minimum Data Set (MDS) dated 07/18/22 revealed a Brief Interview for Mental Status of 15 indicating the resident was cognitively intact.	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on resident, resident representative, and	M 615	Resident #3 discharged from the facility on 08/23/2022.	11/18/22

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M 615	Continued From page 7 staff interviews, record review and facility policy review, the facility failed to provide treatment to an existing pressure ulcer consistent with professional standards as evidenced by failure to document treatment, skin assessments, and wound measurements for 1 (one) of 8 (eight) residents evaluated for skin conditions. Resident #3 Findings include: Record review of the facility policy titled, "Skin Care Guidelines", dated July 2019, revealed, "To provide a system for evaluation of skin to identify individual interventions to address risk and a process for care of changes/disruption in skin integrity. All those admitted will be observed for baseline skin condition and evaluated for risk of skin breakdown within 24 hours of admission. The findings will be documented in the electronic medical record. Weekly review of the patient's/resident's skin will be completed by the nurse and documented in the electronic medical record". Policy also revealed, "When an open area is identified.....Document evaluation of wound in electronic medical record including: location and staging (only Pressure Ulcers/Injuries are staged); size (Length x width x depth) presence and location of undermining and tunneling; exudate/if present: type, color, odor, and approximate amounts; pain/if present: type and frequency; wound bed: color and type of tissue, including evidence of healing (granulation) or necrosis (slough and eschar); reassess, re-evaluate and revise interventions when progress is not noted within 14 days. If there is any deterioration of wound statuses initiate comprehensive re-evaluation, MD and/or patient/resident representative notification. Key	M 615	On 10/10/2022, skin audits conducted on all residents by the Director of Nursing, Registered Nurse Unit Manager, Treatment Nurse and Administrator. No new wounds were noted. Verified all residents had current wound care orders and care plans. All residents have the potential to be affected by this practice. On 10/10/2022, the Director of Nursing, Registered Nurse (RN) Unit Manager, Administrator and treatment nurse assessed all residents to assure that treatments were being provided as ordered. Any negative variance was addressed immediately. Administrator in-serviced the treatment nurse and Registered Nurse Unit Managers on Skin/Wound Prevention Policy on 10/10/22. Nurses will provide treatments as ordered and document accordingly. Nurses to complete weekly skin evaluations on each resident. Beginning 10/17/22, Licensed nursing staff educated by the Administrator regarding the Skin/Wound Prevention Policy. Beginning 10/17/2022, the Director of Nursing ,Administrator, or RN Unit Manager will conduct an audit of 10 residents per week to ensure the facility implements interventions, documents evaluations and completes weekly skin evaluations of all residents. The audits will be conducted three times a week for four weeks, then weekly for four weeks,	

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M 615	Continued From page 8 elements: initial skin evaluation is completed and documented within 24 hours of admission, any skin risk identified has corresponding interventions in the plan of care, interventions are observed in place, weekly skin evaluations are completed and documented, physician notification is timely, patient/resident representative notification is timely." Resident #3 An interview by phone with the complainant, Resident Representative (RR) on 9/28/22 at 11:35 AM, stated that the resident had a wound and she felt like the facility was not doing wound care as needed. The RR confirmed that Resident #3 was discharged on 08/23/22. An interview with the Administrator on 9/30/22 at 2:15 PM, revealed the electronic Treatment Administration Record (TAR) contained scheduled wound care that was not documented as completed, so therefore, could not be verified that care was completed as ordered by the Physician. She confirmed that wound treatments as ordered and the weekly skin and wound assessments were not consistently performed and that can lead to a delay in identifying concerns, rapid decline of the wound and or decline of the resident's overall condition. An interview with Registered Nurse (RN) #1, on 10/4/22 at 9:35 AM revealed the facility does not have a wound nurse at this time but she and another nurse are unit managers and the two of them are responsible for the weekly wound assessments, pictures, measurements, and documentation of findings and they are responsible for documenting these in the computer. She revealed the weekly skin	M 615	then monthly for two months. Findings of the audit were brought to QA 10/28/2022, and will be brought to the Quality Assurance and Performance Improvement Committee for review and revision as necessary for three months.	

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assessments are to be done by the floor nurses and documented in the computer. She stated the unit managers help train other nurses by rounding with them during the care. She also revealed the unit managers do daily wound care, but if they are unavailable or on weekends, the floor nurses are responsible for making sure the care is done and the completed care is documented in the computer. She confirmed the resident has an order for wound care to the sacral area daily, but the electronic TAR did not indicate this had occurred. RN #1 also revealed the skin assessments and the wound assessments were to be done weekly, but when reviewing these records she confirmed that these assessments had not been documented as completed.

An interview with the Director of Nursing (DON) on 10/4/22 at 10:55 AM, revealed she felt the care was done, but the documentation did not verify that. She confirmed that the documentation for Resident #3 revealed the resident did not receive the wound care and the wound and skin assessments and this could have lead to a new area of skin concern or could have possibly lead to worsening of skin areas.

Record review of a Physician's Order dated 6/30/22 revealed an order to clean pressure wound to sacrum with normal saline (NS), pat dry, apply dermaseptin, cover with foam one time a day.

Record review of the TAR for August 1 - 22, 2022 revealed that the resident's TAR was not marked as completed for wound care on the sacrum as ordered on 8/2/22, 8/4/22, 8/6/22, 8/8/22, 8/12/22, 8/13/22, 8/20/22. The TAR revealed on 8/15/2022, the resident refused the wound care. Record review revealed that the Wound and Skin

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M 615	Continued From page 10 assessment indicated the resident had a Stage II 4.38 cm x 8.99 cm on 05/27/22 assessment. The wound and skin assessment on 06/24/22 revealed Stage II 0.55 cm x 1.21 cm and the wound assessment revealed the wound was resolved on 08/17/22. Record review of Skin and Wound - Total Body and Skin Assessment revealed the assessments were completed on 6/15/22, 6/23/22, 6/29/22, and 7/13/22. Resident #3 was admitted to the facility on 5/26/22 and was discharged on 8/23/22. Record review of Skin and Wound Evaluations for Stage 2 Pressure Ulcer (PU) present on admission to the sacrum revealed the wound was evaluated on these dates: 5/27/22, 6/2/22, 6/7/22, 6/14/22, 6/24/22, 6/30/22, 7/5/22, 7/14/22, 7/22/22, 7/29/22, 8/5/22 (no measurements listed), 8/17/22 Progress listed as resolved. Record review of Resident #3's face sheet revealed the resident was admitted to the facility on 5/26/22 with diagnoses which included: Heart Failure, Presence of Cardiac Pacemaker, Hypertensive Chronic Kidney Disease, Chronic Obstructive Pulmonary disease, and Hypertension. Record review of the Minimum Data Set (MDS) dated 7/7/22, revealed a Brief Interview for Mental Status (BIMS) of 14, indicating the resident was cognitively intact.	M 615		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		11/18/22

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M 640	Continued From page 11 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review and facility audit review, the facility failed to ensure that the residents environment remained free of accident hazards and that each resident received adequate supervision to prevent accidents for two (2) of six (6) residents reviewed. Residents #3 and #4. Findings include: Record review of the "Medication Administration Competency Audit - Oral Meds", undated, revealed, "... 9. Identified resident by name or picture. 10. Observe resident swallow medications. 11. Document after administration of meds." Record review of facility policy titled, "Falls", dated February 2017, revealed, "Purpose: To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls." Policy also revealed, "If the fall occurred from chair/wheelchair, evaluate reason for fall in order to choose appropriate intervention". Record review of a letter on the facility's letterhead dated 10/4/22 and signed by the Administrator revealed, "To Whom It May Concern, (Proper name of facility) does not have a Prevention of Accidents and Hazards policy".	M 640	Resident #3 discharged from the facility on 08/23/2022. On 10/6/2022, Administrator inserviced the Social Worker regarding the policy for transfer assistance. On 09/27/2022, Resident #4 was evaluated by the RN Unit Manager with no negative findings. On 09/27/2022, Licensed Practical Nurse #2 was in-serviced by the Administrator on the policy for Medication Administration and staying with the resident until all medications are taken. All residents have the potential to be affected by this practice. On 09/27/2022, facility wide tour conducted by the Administrator and Director of Nursing to assure no other medication were left at the bedside, with no negative findings. On 10/10/2022, the Director of Nursing and Administrator conducted a review of falls for the past 2 months to determine if other falls occurred with the assist of staff. None were noted. Beginning 10/17/2022, the Director of Nursing/Administrator in-serviced staff	

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M 640	Continued From page 12 Resident #3 An interview by phone on 9/28/22 at 11:35 AM, with Resident #3's daughter revealed the resident had several falls in the facility and one of the falls was due to the Social Worker (SW) helping Resident #3 out of the wheelchair and she fell. She stated she did not have an injury with the fall. An interview with the Director of Nursing (DON) on 9/30/22 at 10:00 AM, revealed the resident did have some falls in the facility, but none of the falls were with a major injury. She stated one fall involved the SW assisting the resident out of her wheelchair so she could walk. She stated the SW had good intentions, but she should have asked a Certified Nursing Assistant (CNA) or nurse for assistance. She confirmed the facility failed to prevent a fall due to the SW, who was not trained with transfers, assisting Resident #3 with a transfer. An interview with SW on 9/30/22 at 2:00 PM, revealed Resident #3 was in her wheelchair in the hallway and asked for her to help her get up. She stated she thought the resident would be able to walk on her own and just needed help to stand and she was trying to help her. She stated the resident walked from the wheel chair into the common area and she fell. She was in the hallway by the SW office, and she fell approximately 10 feet from her wheelchair in the common area. She stated in the past she did work as a Nursing Assistant, but that was years ago and she was not certified. She stated she was educated by the DON on this situation and how she should have asked a nurse or a CNA to assist a resident with transfers. An interview with the Administrator on 9/30/22 at	M 640	regarding Accidents and Hazards and Fall Prevention. Beginning 10/17/2022, The Administrator in-serviced licensed nurses regarding the policy for Medication Administration. Beginning 10/17/2022, the Administrator, Director of Nursing Services/Unit Manager will conduct medication pass observation audit three times weekly for four weeks, then weekly for four weeks, and monthly for two months. Negative findings will be addressed and corrected immediately. Beginning 10/17/2022, the Administrator or Director of Nursing will conduct observation rounds to ensure resident transfers are safe and in accord with transfer policy three times a week for four weeks, then weekly for four weeks, then monthly for three months. Findings were brought to QA 10/28/2022 and will be brought to the Quality Assurance Performance Improvement Committee for review and revision as necessary monthly for three months.	

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	41TM	A. BUILDING: _____ B. WING _____	C 10/04/2022

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M 640	Continued From page 13 2:15 PM, revealed Resident #3 was discharged prior to her working at the facility and she had no knowledge of the situation with the fall involving the SW with the resident, but she would ensure all staff would be trained on their roles. She confirmed the facility failed to prevent a fall by an untrained staff member assisting with the transfer of a resident. Record review of incident report dated 8/18/22 revealed the nursing description as, "Resident was sitting in wheelchair in common area across from A/B nurses station. Social worker was walking by and resident asked her to help her get up and walk. Social worker helped her up and resident fell." Resident description, "Resident asked for help to get up and walk." Record review revealed that the resident did not have an injury and was assessed by a nurse and placed back into the wheelchair and the SW was counseled one on one and in-serviced. Record review of the Admission Record revealed Resident #3 was admitted to the facility on 5/26/22, with diagnoses which included Heart Failure, History of Falling, Presence of Cardiac Pacemaker, and Chronic Obstructive Pulmonary Disease. Record review of Minimum Data Set (MDS) dated 7/7/22 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that Resident #3 was cognitively intact. Resident #4 An observation and interview on 9/27/22 at 6:40 PM, revealed Resident #4 in her room sitting in the wheelchair. An observation of a medication	M 640		

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cup containing two (2) pills was observed on the overbed table. An observation of the medication: one pale brownish scored capsule-shaped tablet with markings on one side of "A" and the other side with markings of "0 9" identified as Mirtazapine 30 mg. The other medication was a dark green and light green capsule with imprint of "IX 657" identified as Hydroxyzine 25 mg. She stated she took her other evening medications and the nurse left these for her to take when she is ready for bed. She stated she is 96 years old and has taken the "Restoril" for 60 years and it helps her to sleep and to not be nervous. Registered Nurse (RN) #1, Unit Manager, came into room and confirmed the medications at her bedside and stated these are the Resident #4's Vistaril and Remeron that are ordered for her and should not be left at the bedside. She confirmed the nurse should watch the resident take the medications and not leave the medication at the bedside. She stated Licensed Practical Nurse (LPN) #2 is the nurse on the medication cart administering medications to this hall and they should not be left in a resident's room for them to take later. RN #1 removed the medications from Resident #4's room.

An interview with LPN #2 on 9/27/22 at 6:50 PM, stated she handed Resident #4 the cup of medications and she went back to the medication cart in the doorway to get the resident's inhaler and she could see the resident. Then, she stated she did not see the resident actually take the medications since she was getting the resident's inhaler out of the cart and stated the resident prefers to take those two medicines when she gets ready for bed. She stated, "it's my fault and I take responsibility for it. I should have never walked away and I should have made sure she took all of her meds." She stated she has been

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in-serviced on the proper way to administer medications which includes watching the resident take the medication and not leaving them at bedside.

An interview with the Director of Nursing (DON) on 9/27/22 at 7:00 PM, revealed medications should not be left at the bedside and the nurses must ensure the resident takes the medications as ordered.

An interview with the Administrator on 9/30/22 at 2:15 PM, confirmed the facility failed to ensure medications were administered properly and not left at bedside. She revealed safety first should always be followed and if a resident prefers medications to be administered at a different time, the physician needs to be notified and the order changed to accommodate the resident's preference. She confirmed the nurse left the medication at the bedside for the resident to take when she was ready to take them at bedtime.

Interview with the Administrator on 10/4/22 at 11:55 AM, revealed the facility had no policy for accidents and hazards.

Record review of Resident #4's Order Summary Report revealed an order dated 9/20/22 for Hydroxyzine Pamoate Capsule - give 25 milligrams (mg) by mouth at bedtime for anxiety and an order dated 3/30/21 for Remeron Tablet (Mirtazapine) - give 30 mg by mouth at bedtime for depression/weight loss.

Record review of the resident's Medication Administration Record for 9/27/22 revealed Hydroxyzine Pamoate Capsule and Remeron Tablet were both signed out as administered at 6:00 PM by LPN #2.

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M 640	Continued From page 16 Record review of Resident #4's Admission Record revealed Resident #4 was admitted to the facility on 2/22/16 with diagnoses which included Anxiety Disorder, Hypertension, Gastroesophageal Reflux Disease, Major Depressive Disorder. Record review of Resident #4's quarterly Minimum Data Set (MDS) dated 8/29/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #4 was cognitively intact.	M 640		