STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. BUILDING _____ B. WING _____	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with one (1) complaint, MS #20259 at the facility from 3/13/23 to 3/16/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited F679 and F695 during the survey. The SA investigated MS #20259 for Abuse/Neglect and cited no deficiencies. The facility held a license for 60 beds with a census of 49.	F 000		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide an ongoing resident centered activities program for nine (9) of the nine (9) residents sampled. This has the potential to affect 49 of the 49 residents residing in the facility. Residents #5, #12, #15, #18, #20, #21, #30, #31, and #38 Findings include:	F 679	The center corrected the deficiency as it relates to Resident #5, #12, #15, #18, #20, #21, #30, #31, and #38 by ensuring that activities were held by the Social Services Director as posted on the calendar beginning on March 16, 2023. All current and new residents who prefer to participate in activities have the	4/17/23

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

Electronically Signed | 03/31/2023

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F 679	Continued From page 1 Review of the facility's policy, "Activities," dated April 2022, revealed, " POLICY: It is the policy of this center to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Center-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community ..." An observation on 3/13/23, at 10:58 AM, revealed five (5) residents sitting in front of the nurse's station. There were no activities taking place in the facility at this time. Record review of the facility's activity calendar dated 3/13/23, revealed "Morning Social" and "Reminiscing," were scheduled during this time. An observation on 3/13/23, at 2:30 PM, revealed several residents sitting in front of nurse's station, with no activities taking place. Record review of the facility's activity calendar dated 3/13/23, revealed "Who's Bag, is it?" scheduled for this time. Observation on 3/14/23, from 10:00 to 11:00 AM, once again revealed residents sitting in front of the nurse's station, with no activities taking place. Record review of the facility's activity calendar dated 3/14/23, revealed "Morning Social" and "Current Events" were scheduled during this time.	F 679	potential to be affected by the deficient practice. A resident council meeting was held by the Activity Director on March 27, 2023 to identify resident preferences for activities. All residents in attendance were interviewed regarding their choices of activities for weekends and additional week days and evenings. The center's activity calendar was revised on March 28, 2023 by the Activity Director, with preferences and additions. Each resident's plan of care was reviewed and revisions made as needed for preferences. The Activity Director will coordinate with the Social Services Director, Transportation Driver, and/or Volunteer when she will be out of facility during scheduled activity to ensure activity occurs. To ensure sustainability of the center's corrective action, the Activity Director, Administrator, or Manager on Duty, beginning on March 27, 2023, will monitor five residents five days per week for two weeks, then three days per week for four weeks to ensure activities are performed and meet resident's needs. Any negative findings will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months, beginning April 17, 2023.	

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F 679	Continued From page 2	F 679		

During interviews with the nine (9) residents present on 3/14/23 at 2:00 PM, at the Resident Council meeting, each resident confirmed that they usually had activities during the week, unless the Activity Director was off. They confirmed that with the Activity Director off this week, they haven't had any of the activities listed on the activity calendar. The Council members complained that there had been nothing to do. They also complained that they didn't have activities on Saturdays, because the Activity Director was off on the weekends. They did, however, confirm that they had church services on Sundays, but that was the only thing scheduled during the weekends.

An observation on 3/15/23 from 10:00 AM to 11:00 AM, once again revealed residents sitting in front of the nurse's station with no activities taking place.

Record review of the facility's activity calendar dated 3/15/23, revealed "Morning Social and "Parachute" had been scheduled for that time.

During an interview on 3/15/23 at 2:39 PM, the Administrator confirmed the Activity Director is on vacation this week and doesn't work on weekends. The Administrator revealed the Social Worker is responsible for providing activities for the residents this week.

During an interview on 3/15/23 at 11:07 AM, with the Social Worker, she stated she had tried to assist with activities when she could, but with the referrals that she gets, she had not been available to consistently oversee the scheduled activities when the Activity Director was unavailable this week or at any time on the

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F 679	Continued From page 3	F 679		

weekends, as she is also off on the weekends. The Social Worker said she thought the Activity Director and one of the certified nurse aides (CNA's) had talked about the CNA assisting with activities when the Activity Director was unavailable.

Resident #5

Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/21/22, revealed, Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact. Review of section F revealed, it was very important to Resident #5 to do favorite activities.

Resident #12

Record review of the MDS, with an ARD of 11/9/22, revealed, Resident #12 had a BIMS score of 13, which indicated the resident was cognitively intact. Review of section F revealed, it was somewhat important for Resident #12 to do favorite activities.

Resident #15

Record review of the MDS, with an ARD date of 11/22/22, revealed, Resident #15 had a BIMS score of 15. Review of section F revealed, it was very important to the resident do favorite activities.

Resident #18

Record review of the MDS, with an ARD date of 7/5/22, revealed, Resident #18 had a BIMS score of 15, which indicated the resident was cognitively

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F 679	Continued From page 4	F 679		

intact. Review of section F revealed, it was very important to Resident #18 to do favorite activities.

Resident #20

Record review of MDS, with an ARD of 4/13/22, revealed, Resident #20 had BIMS score of 15, which indicated the resident was cognitively intact. Review of section F revealed, it was very important to Resident #20 to do favorite activities.

Resident #21

Record review of the MDS, with an ARD of 1/30/23, revealed, Resident #21 had a BIMS score of 15, which indicated the resident was cognitively intact. Review of section F revealed, it was very important to Resident #21 to do favorite activities.

Resident #30

Record review of the MDS with an ARD of 10/3/22, revealed, Resident #30 had a BIMS score of 15, which indicated the resident was cognitively intact. Review of section F revealed, it was very important to Resident #30 to do favorite activities.

Resident #31

Record review of the MDS with an ARD of 11/10/22, revealed, Resident #31 had a BIMS score of 13, which indicated the resident was cognitively intact. Review of section F revealed, it was important to Resident #38 to do favorite activities.

Resident #38

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F 679	Continued From page 5 Record review of the MDS, with an ARD of 1/17/23, revealed Resident #1 had a BIMS score of 15, which indicated the resident was cognitively intact. Review of section F revealed, it was very important to Resident #38 to do favorite activities.	F 679		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to post cautionary and safety signs indicating the use of oxygen for one (1)of one (1) sampled residents. Resident #198 Findings include: A record review of the facility's policy, "Applying An Oxygen-Delivery Device," undated, revealed " ... IMPLEMENTATION ... 9. Post "Oxygen in Use" signs on wall behind bed and at entrance to room ...12... Alerts visitors and are providers that oxygen is in use ..." On 3/13/23 at 11:02 AM, an observation of Resident #198 revealed the resident lying in bed, wearing a nasal cannula. An oxygen concentrator	F 695	The Assistant Director of Nursing Services (ADNS) corrected the deficient practice as it relates to Resident #198 on March 15, 2023, by placing oxygen signage on doorway of the resident room. All residents receiving oxygen have the potential to be affected by the deficient practice. On March 15, 2023, the Director of Nursing Services (DNS) and ADNS performed an audit of all residents to ensure that oxygen signage was present on the room door/doorway for any resident receiving oxygen. No other residents were identified without oxygen signage. Licensed staff members were	4/17/23

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F 695	Continued From page 6 (a medical device used to deliver oxygen) was noted next to the resident's bed and turned on. There was no cautionary signage posted at the entrance to the resident's room or within the room to indicate that oxygen was in use. Observations on 3/14/23 at 3:00 PM and again on 3/15/23 at 11:36 AM, revealed Resident #198, the resident sitting in his room with oxygen in use. There continued to be no cautionary signage within the resident's room or near the entrance to the resident's room that indicated oxygen was in use. A record review of Resident #198's "Admission Record," revealed the facility admitted the resident on 3/2/23, with the diagnosis of Chronic Obstructive Pulmonary Disease Heart Failure and Chronic Kidney Disease. A record review of the "Order Summary Report," for Resident #198 with active orders as of 3/16/23, revealed an order for "O2 (oxygen) via nasal cannula at 2L/min (two liters per minute) continuous every shift related to Chronic Obstructive Pulmonary Disease." A record review of Resident #198's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact, and review of Section O revealed, oxygen in use. On 3/14/23, at 11:36 in an interview with Registered Nurse (RN) #1, she confirmed the resident was receiving oxygen. The nurse also confirmed that there was not a sign in the resident's room or upon entrance to the room	F 695	educated on March 15, 2023 by DNS and ADNS regarding the expectation that all residents with oxygen in use will have oxygen signage on the door/doorway of resident room. Beginning on March 20, 2023, the DNS, ADNS, or Unit Manager will audit five residents per week for two weeks, then three residents per week for four weeks to ensure oxygen signage is posted on the room door/doorway for residents receiving oxygen. Findings of these audits will be reported and discussed monthly for three months in Quality Assurance Performance Improvement (QAPI) meeting and adjusted as needed to ensure the safety of residents, beginning April 17, 2023.	

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F 695	Continued From page 7 indicating that oxygen was in use. On 3/16/23 at 10:15 AM, in an interview with the Director of Nursing (DON) she confirmed there should have been a sign near the entrance to the resident's room and in the resident's room to inform staff and visitors that oxygen was in use. She explained the purpose of the signage is to ensure resident and staff safety.	F 695		