STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	78EH	A. BUILDING: _____ B. WING _____	04/27/2023

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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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 4/25/23-4/27/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm at M500 related to resident rights and M610 related to Activities of Daily Living (ADL). The census at the time of the survey was 111 and the facility is licensed for 119 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 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	M 500		6/2/23

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M 500	Continued From page 1 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, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

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;

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,

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M 500	Continued From page 3 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 Based on observation, resident and staff interviews, record review and facility policy review the facility failed to honor a resident's privacy as evidenced by a sign posted over the resident's	M 500	Immediate action initiated on 4/28/23 by Director of Nursing Services (DNS) to correct the issue with #65 included reviewing the advance directives with the resident. A new advanced directive was	

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M 500	Continued From page 4 bed that read two (2) stool samples needed with the resident's name and date, for one (1) of 111 residents reviewed for dignity. Resident #99 Findings include: Review of the facility policy titled, "Resident's Rights and Quality of Life" with a revision date 5/1/12 revealed under, "Policy Statement ... It is the policy of (Proper Name) that all residents have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the facility." This review revealed "A resident has the right...To personal privacy and confidentiality of personal and clinical records." An interview and observation on 04/25/23 at 10:35 AM, with Resident #99 revealed a handwritten sign posted on the wall above the resident's bed that read, Resident #99's name and the need to collect two (2) stool samples. On interview Resident # 99 revealed he was not aware the sign had been posted on his wall. An interview and observation on 4/26/23 at 10:55 AM, with Registered Nurse (RN) #1 confirmed that there was a sign posted on Resident #99's wall dated 4/4/23, which listed the residents name and the need to collect 2 stool samples. She immediately removed the sign and stated, "I wouldn't like that posted on my wall for others to see; it's a privacy thing." An interview with the Director of Nursing (DON) on 4/26/23 at 3:50 PM, confirmed that posting the sign on Resident #99's room wall with his name and the need for stool samples was a dignity issue and should not have been placed there.	M 500	signed by the resident. Immediate action taken included 100% review of all resident's advanced directive paper work on 5/1/23 by the Interdisciplinary team (IDT) to identify any other residents that might have been effected by this practice. All residents were at risk for this issue. Any resident that was able to make their own decision was then provided education on the Physician Orders Sustaining Treatment (POST) form and given the opportunity to sign the POST form. If the resident's chose not to sign the form and preferred the Responsible Party (RP) to sign, documentation of such was added to the medical record. Going forward to assure this issue does not occur again, any new admit is encouraged to sign their own advanced directive. Any new admit with a Power of Attorney (POA) will be encouraged to sign their own advanced directive (AD) paperwork unless the POA specifically states another person is legally responsible at the time of admission. If the resident waives the decision to sign their own paperwork/Advanced Directive (AD) it will be documented as such in the medical record. An in-service was provided to the IDT on 5/1/23 by the Administrator to review updated process of resident's signing their own advanced directive paperwork. On 5/1/23 The administrator began auditing 5 residents POST form weekly x4 weeks, then monthly x2 months to assure new process is being followed. Any variance to the plan of correction will be corrected immediately and carried to	

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M 500	Continued From page 5 Record review of Resident #99's Admission Record revealed the resident was admitted to the facility on 12/19/2022 with diagnoses that included Other Seizures, Non-Traumatic Intracerebral Hemorrhage in Hemisphere, Subcortical, and Dysphagia, unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/24/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 7, which indicated Resident #99 is severely cognitively impaired.	M 500	Quality Assurance Performance Improvement (QAPI) x 3 months with first QAPI scheduled for 5/24/23, or longer if needed.	
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review and facility policy review the facility failed to provide services to maintain hygiene for a resident who was dependent on the staff as evidenced by long nails with a brown substance under each nail and 1/4-inch-long gray hair on the resident's chin for one (1) of 111 resident's	M 610	The unit manager assessed resident # 1 on 4/25/23 and immediately assured the nails were trimmed and clean and the facial hair was removed. Education was initiated on 4/26/23 by the Director of Nurses (DNS) and Director of Clinical Education (DCE) to the Certified Nurse Aides (CNA) regarding care of nails and facial hair. This resident's care plan was	6/2/23

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M 610	Continued From page 6 reviewed. Resident #1 Findings include: Review of the facility policy titled, "Nail Care" with no revision date revealed under, "Policy ...The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health." Also revealed under, "Policy Explanation and Compliance Guidelines:.. #3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. #4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises..." Review of the facility policy titled, "Grooming a Resident's Facial Hair" with no revision date revealed under, "Policy ...It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice..." An observation on 4/25/23 at 10:56 AM, revealed Resident #1 had long, gray chin hairs extending approximately one-fourth (1/4) inch from the chin. Further observation revealed long, jagged fingernails on both hands extending approximately three-eight (3/8) inches from the tips of fingers with a brown substance underneath each nail. An interview and observation on 4/26/23 at 10:45 AM, with Certified Nurse Aide (CNA) #1 confirmed that Resident # 1 did have long chin hair, and that it should have been shaved. She also confirmed that Resident # 1's nails were long and did not look clean. She stated, "No, her nails	M 610	reviewed and updated by the DNS on 4/26/23. All residents are potentially affected by this practice The DNS assured that the nursing staff conducted a 100% audit on 4/26/23 of all residents to assess for facial hair and jagged nails Any residents identified with either unwanted facial hair or long/jagged nails immediately corrected. Going forward, systemic changes implemented on 4/28/23 to avoid this issue included implementing an environmental rounds check list to include observation of nails and facial hair. Any resident with log nails or facial hair should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the Administrator (ADM) on 4/28/23 with team members regarding updated environmental rounds along with implementation. CNAs education was initiated by the DCE on 4/26/23 regarding checking nails and facial hair as part of their daily care of residents. On 4/28/23, the Administrator began an audit of a minimum of 5 residents weekly then monthly x 2 months of residents to assure that facial hair is removed and nails are trimmed in accordance with the resident's wishes. This process improvement plan will be reviewed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3	

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M 610	Continued From page 7 haven't been cut or cleaned," and confirmed that the resident could scratch her skin and cause an infection. She stated that the CNAs were responsible for cutting the resident's nails if the resident did not have diabetes and they are responsible for cleaning the residents' nails and should clean them during showers or whenever the nails become dirty. An interview and observation on 04/26/23 at 11:00 AM, with Registered Nurse (RN) #1 confirmed that the resident had long nails with a brown substance underneath and confirmed that the resident had long gray hair on her chin. She confirmed that Resident # 1 is not a diabetic, and the CNAs were responsible for trimming and cleaning the nails of a non-diabetic resident. She stated that the nurses usually follow up at the end of the day to ensure the nail care was performed. She revealed long dirty nails could cause infection and be a safety hazard to the resident. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 09/27/2017 with medical diagnoses that included Unspecified Psychosis Not Due to a Substance or Known Physiological Condition and Anxiety Disorder. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #1 is moderately impaired and under section G, the resident requires one (1) person physical assistance with personal hygiene.	M 610	months beginning with QAPI on 5/24/23 to assure continued compliance.	

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M 640	Continued From page 8	M 640		
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 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: Based on resident and staff interview, record review and facility policy review the facility failed to perform a safe smoking assessment for one (1) of five (5) residents reviewed for smoking. Resident #58 Findings include: Review of the facility policy titled, "Smoking Policy", with an effective date of May 1, 2021, revealed under "Purpose 1. To maximize our ability to provide a safe environment for all residents, visitors, and staff. 2. To perform assessments, which determine a resident's ability to smoke safely and determine what, if any, additional measures are needed to protect residents from possible self-inflicted injury due to smoking habits...Procedure 1. Upon admission, quarterly, and with any change in condition, it is to be determined by the nurse if the resident requires supervision while smoking. Utilize the "Safe Smoking Assessment..." An interview with Resident #58 on 4/26/23 at 3:00 PM, verified that she was a smoker but was unsure when she began smoking again. An interview with the Director of Nurses (DON) on	M 640	On 4/26/23 the Director of Nurses (DNS) assessed resident #58 smoking habits and determined no negative consequences of resident smoking. The person centered care plan was updated along with the smoking assessment on 4/27/23 by the Minimum Data Set nurse. On 4/27/23 the DNS performed a 100% audit of all smokers to assure that each smoker had a smoking assessment and person centered care plan. On 4/27/23, the DNS completed a 100% audit of all Smoking Evaluations to determine if any other residents flagged for smoking and then compared this with the care plan. No additional variances were found. Any resident with the desire to smoke may be affected by this practice. The Administrator determined the Activities Department to be the process owner for smoking beginning 5/1/23. Going forward, the Activities Director will ensure completion of smoking assessment and care plan at the time of admission or when there is a change in smoking desire.	6/2/23

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M 640	Continued From page 9 4/26/23 at 3:20 PM, revealed that the floor nurse should have completed a safe smoking assessment for Resident #58. An interview with Registered Nurse (RN) #1 on 4/26/23 at 3:35 PM, revealed that she completed the Clinical Health Status Evaluations if they were due when she was on duty. She revealed that it contained a question about smoking and if the resident smokes the Safe Smoking Assessment should be completed. She does not recall when Resident # 58 started smoking. An interview with the Minimum Data Set (MDS) Nurse # 1 and MDS Nurse # 2 on 4/26/23 at 3:39 PM, revealed that the Clinical Health Status Evaluation is completed on admission and quarterly in conjunction with the MDS, by the floor RN. They both revealed that if a resident smokes it should be indicated on the evaluation. They revealed that when Resident # 58 was admitted to the facility on 12/22/22 she was too sick to smoke, and they knew that she was not smoking at that time but were not aware that Resident # 58 had begun smoking and did not know when she started smoking. They also revealed that when Resident # 58 started smoking the floor RN should have completed a safe smoking assessment. An interview with the DON on 4/26/23 at 3:50 PM, confirmed that Resident #58 should have been assessed for safe smoking and that failure to assess Resident # 58 for safe smoking could have put Resident # 58 at risk for injury. A record review of Resident #58's Clinical Health Status Evaluation, completed on 3/29/23 in conjunction with the Quarterly MDS, revealed under Respiratory/Cardiovascular section,	M 640	The Minimum Data Set nurse will assure that care plans will be developed based on smoking assessment On 4/28/23, the Director of Clinical Education (DCE) completed education with nurses on accuracy of completing the clinical health assessment and as needed smoking evaluation. Beginning 4/28/23, the DNS will review all new admissions or readmissions in Clinical Start up to determine that their desire to smoke has been evaluated. The Interdisciplinary Team (IDT)began meeting 5/2/23 every Tuesday and Thursday to review assessments and care plans for accuracy. To assure continued compliance, on 5/1/23, the Administrator began auditing smoking assessments and care plans are completed for all new admissions weekly x 4 and then monthly x 2 to assure that residents with the desire to smoke are identified and have person centered care plans for smoking. Any variance will be corrected immediately. This process improvement plan will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance.	

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M 640	Continued From page 10 question number three (3)." Does resident smoke" was left unanswered. A record review of the list of smokers in the facility confirmed that Resident # 58 was a smoker. A record review of Resident # 58's medical record revealed there was no assessment by a qualified professional to determine if Resident #58 could safely smoke. A record review of Resident # 58's Admission Record revealed that the resident was admitted to the facility 12/22/22, with diagnoses that include Acute on Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure and Peripheral Vascular Disease, Unspecified. A record review of Resident # 58's Minimum Data Set with an Assessment Reference Date (ARD) of 3/29/2023, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.	M 640		