STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 at the facility from 04/16/23 through 04/19/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F693, F695, F791, F812, F880. The facility held a license for 120 beds, with a census of 91.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		5/30/23

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

Electronically Signed | 05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 693	Continued From page 1 Based on observation, interview and record review the facility failed to provide percutaneous endoscopic gastrostomy (peg) feeding tube care in a manner to prevent complications for one (1) of three (3) residents reviewed with peg feeding tubes. Resident #64 Findings include: A record review of the facility's "Care of a Gastrostomy or Jejunostomy Tube Competency Audit" provided by the Director of Nursing (DON) revealed, " ...Cleansed skin around site with water and soap using gauze ...". Further review revealed the document did not contain steps for the actual cleansing procedure to include the direction of wipes and the rotation of gauze. A record review of the "Order Summary Report", with "Active Orders As Of: 04/19/2023" revealed Resident #64 had a Physician's Order dated 8/2/22 to "Clean peg tube site with soap and water and leave open to air q (every) shift ..." On 04/18/23 at 2:20 PM, in an observation of Licensed Practical Nurse (LPN) #2 providing peg feeding tube care to Resident #64, she cleaned the peg feeding tube insertion site with a moistened gauze, using a circular motion wiping four (4) times around the site, without folding or rotating the position of the gauze. LPN #2 rinsed the peg feeding tube insertion site with a clean moistened gauze by folding the gauze after each wipe. She then used a clean dry gauze to dry the site, using a circular motion, wiping four (4) times around the insertion site, without folding or rotating the position of the gauze after each circular wipe.	F 693	1. Resident #64 was assessed 4/19/23 by Director of Nursing with no complications noted at percutaneous endoscopic gastrostomy tube (PEG) site. Licensed Practical Nurse (LPN) #2 was in-serviced on 4/20/23 on proper care of PEG site by Assistant Director of Nursing. All residents with PEG's were assessed on 4/20/23 with no complications noted. 2. All residents who have a PEG have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Director of Nursing/Assistant Director of Nursing in-serviced all Licensed Nurses on proper PEG site care 4/20/23-5/5/2023. The Director of Nursing will assess, with return demonstration, each licensed nurse performing PEG site care by 5/12/23. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will observe a nurse on each medication cart performing PEG tube site care 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper delivery of PEG tube site care. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 693	Continued From page 2 On 04/18/23 at 2:40 PM, in an interview with LPN #2, she confirmed that she cleaned around the peg tube insertion several times with the same gauze and that she should have cleaned one side of the peg site, discarded the gauze, and used a clean gauze each time for cleaning and drying the area. She stated her actions could potentially cause Resident #64 to acquire an infection. On 04/19/2 at 09:31 AM, in an interview with the DON, she stated that LPN #2 should have cleaned the peg feeding tube site by using gauze, discarding, and using a clean gauze with each wipe around the site. She stated LPN #2 had contaminated the peg feeding tube site during cleaning and her actions could put the resident at significant risk for infection. A record review of the "Admission Record" revealed the facility admitted Resident #64 on 02/01/23 and he had diagnoses including Cerebral Infarction, Unspecified Protein-Calorie Malnutrition, and Gastrostomy.	F 693	action.	
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 interview, observation, record review,	F 695	1.Resident #74 was assessed on 4/19/23	5/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 3 the facility failed to adhere to accepted standards of practice for the proper storage of a nebulizer mask for two (2) of three (3) observations. Resident # 74 Findings include: During an observation on 04/16/23 at 11:42 AM, Resident #74 was in bed, and his nebulizer mask was noted directly on the floor. There was no visible container designated to store the nebulizer tubing/mask. On 4/16/23 at 2:54 PM, Resident #74 was observed in his bed. His nebulizer mask continued to be on the floor, with no visible container to store the mask to prevent contamination. On 4/16/23 at 3:04 PM, during an interview with Licensed Practical Nurse (LPN) #2, she explained Resident #74 had scheduled nebulizer treatments, but was unsure how often. She stated that the nebulizer mask should be kept in a bag when it is not in use because of infection control. LPN #2 entered Resident #74's room and confirmed the nebulizer mask was lying on the floor. She also confirmed there was no container or designated area to store the mask to prevent contamination. She explained the nebulizer mask was contaminated and that it was not standard practice for the mask to be on the floor. LPN #2 stated that she would get a plastic bag to store the mask and a new mask for the resident's use. On 04/19/23 at 11:00 AM, during an interview with the Director of Nursing (DON), she explained all oxygen tubing and nebulizer equipment should be	F 695	by the Director of Nursing with no respiratory complications noted. Licensed Practical Nurse (LPN) #2 was in-serviced on 4/20/23 by the Assistant Director of Nursing regarding nebulizer mask storage when not in use. All residents with nebulizers were assessed 4/20/23 with no complications noted. 2. All residents who have nebulizer treatments have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Director of Nursing/Assistant Director of Nursing in-serviced all Licensed Nurses on proper nebulizer storage on 4/20/23-5/5/2023. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will observe nebulizer mask storage 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper nebulizer mask storage. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 stored in a plastic bag while not in use. She stated any equipment noted on the floor should be thrown away and replaced and it is not the facility's normal practice or the standard for those items to be on the floor. She expected the staff to observe for any equipment not properly stored and correct the problem. A record review of the "Admission Record" revealed the facility admitted Resident #74 on 03/01/2023 with diagnoses including Pneumonia and Chronic Obstructive Pulmonary Disease (COPD). A record review of the "Order Summary Report" with "Active Orders As Of: 04/19/2023" revealed Resident #74 had Physician's Orders, dated 3/1/23 for, "for Budesonide Inhalation Suspension 0.5 MG(milligram)/2 ML(milliliter) ...1 vial inhale orally two times a day for COPD" and "Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3 ML) 0.083% (Albuterol Sulfate)1 vial inhale orally every 6 hours as needed for SOB (shortness of breath)."	F 695		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:	F 791		5/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 791	Continued From page 5 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure recommended dental services were provided for one (1) of twenty (20) sampled residents. Resident # 79 Findings include:	F 791	1.Resident #79 was assessed on 4/18/23 for emergency dental service needs. Resident #79 was prescribed antibiotics for abscess from 4/18/23-4/24/23 and had a consult with an oral surgeon on 4/24/2023. Resident #79 is scheduled to return to the oral surgeon on 5/10/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 791	Continued From page 6 Review of the facility's policy, "Dental/Oral Care" dated December 1, 2010, revealed, "Purpose To ensure residents receive care and services and attain or maintain the highest level of oral hygiene... Procedure ...5. Interdisciplinary Care Team will assess for specific needs and review as indicated ...7. Regular and emergency dental care will be provided by contracted services of a dentist. 8. Dentist referrals will be arranged by the Nursing Department or Social Services Departments ..." During an observation, on 04/16/23 at 10:33 AM, Resident #79 was lying in bed and the right side of his face was swollen. During an interview on 04/17/23 at 10:35 AM, with Resident # 79, he said he had an abscess on his right tooth and he had reported it to the nurse. The resident said that it was painful, but the facility was giving him pain medication. Record review of the facility's "Progress Notes" revealed an "MD (Medical Doctor)/FNP (Family Nurse Practitioner) Note", dated 1/23/23 at 14:32 (2:32 PM) for Resident #79, " ...1. Extraction of tooth needed ...3 ...Plavix put on hold. Tooth extraction scheduled for Friday ..." Record review of the facility's "Progress Notes" revealed "General Notes", dated 1/25/23 at 19:29 (7:29 PM) for Resident #79, " ...Appointment with (Proper Name of Local Dentist) January 27, 2023 for tooth extraction ..." Record review of "Progress Notes" from a local Dentist revealed Resident #79 had a dental examination on 1/27/23 and the provider	F 791	for teeth #3, #7, and #17 extractions. All residents were assessed on 4/20/23 by Director of Nursing/Assistant Director of Nursing for emergency dental service needs with no complications noted. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Director of Nursing/Assistant Director of Nursing in-serviced all staff on observing residents for emergency dental care needs on 4/20/23-5/5/2023. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will observe 3 high risk residents for dental service needs 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper dental care. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 791	Continued From page 7	F 791		

documented " ...Felt better and he did also to send him to O.S. (Oral Surgeon) for removal of painful teeth ..."

Record review of the facility's "Progress Notes" revealed "General Notes", dated 2/21/23 at 14:16 (2:16 PM), revealed Resident #79, " ...patient c/o (complained of) tooth pain ...Spoke with CN (Charge Nurse) she stated that she will talk with family member to see if they will come up with a plan to help pay for extraction ..." Review of "General Notes", dated 2/21/23 at 14;28 (2:28 PM), for Resident #79 revealed, " ...Spoke with (Proper name of Resident Representative) and he said that he should have a Dental plan starting on next month. This nurse asked if he could assist him financially to have the tooth removed ...He said that he would go and get him a Milk Shake if he wanted one ..."

Record Review of a "Dental Exam", dated 3/21/21, revealed, " ...Notes ...Patient needs a referral to outside dentist for #3 Extraction. #3 has an existing root canal and crown that has present root decay and an abscess ..."

During an interview on 04/17/23 at 02:37 PM, with Registered Nurse (RN) #1, she stated Resident # 79 was seen by the in-house dentist and received seven (7) days of antibiotics. RN #1 said the resident was sent out to a local Dentist who then referred him to an oral surgeon. His tooth was not pulled because his insurance did not cover oral surgery. RN #1 said she spoke to Resident #1's brother asking him to pay for the oral surgery, but he said that he could not pay for the tooth to be removed.

During an interview on 04/19/23 at 09:45 AM, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 791	Continued From page 8	F 791		

Resident #79's brother, he said the facility called him to inform him that his brother had a bad tooth, his gums were swollen and he had been prescribed antibiotics and pain medication. The brother said he did not have the money to pay for the tooth to be removed and it wasn't covered by insurance. He stated the facility did not say they would help to get another agency to assist with the payment of getting the tooth pulled.

During an interview on 04/19/23 at 11:21 AM, with the Social Worker (SW), she said she had been out sick for two (2) weeks and did not know Resident #79 did not have his tooth pulled when he went to the dentist in January. The SW expressed that she did not begin to look for a provider that would accept the resident's insurance until 4/17/23. She had found an oral surgeon and the resident was scheduled for an appointment on 5/4/23.

During an interview on 04/19/23 at 01:00 PM, with the Administrator and the Director of Nursing, the DON confirmed the facility failed to send the resident to an oral surgeon because she was not aware that the resident was referred to an oral surgeon. The Administrator said she did not know the resident was referred to an oral surgeon as well. The DON said that the SW had been out sick for two (2) weeks, and no one had followed up to find a surgeon that would take the resident's insurance.

A record Review of the "Admission Record" revealed the facility admitted Resident #79 on 8/11/22 with diagnosis of Cerebral Infarction.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 791	Continued From page 9 (ARD) of 2/06/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #79 was cognitively Intact. Review of Section L revealed he had "Mouth or facial pain, discomfort or difficulty with chewing."	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to remove expired, undated, and spoiled food items from storage areas for one (1) of four (4) kitchen observations. This had the potential to affect all residents in the facility receiving food from the dietary department. Findings include:	F 812	1. Expired and improperly stored food items in the kitchen were discarded on 4/16/2023 by the Dietary Manager. All residents consuming oral diets were assessed on 4/19/23 by the Director of Nursing and Assistant Director of Nursing with no complications noted from unsafe food handling.	5/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 812	Continued From page 10 Review of facility's policy, "Food and Supply Storage Procedures, undated, revealed, " ...Remove from storage any items for which the expiration date has expired ..." Review of the facility's policy, "Food Storage: Dry Goods," revised 9/2017, revealed, "All dry goods will be appropriately stored will be appropriately stored in accordance with the FDA Food Code ... 5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate." Review of facility's policy, "Receiving," revised 9/2017, revealed, " ... 5. All food items will be appropriately labeled and dated wither through manufacturer packaging or staff rotation ..." On 4/16/23 at 11:00 AM, during an initial tour of the kitchen with the facility's Cook, an observation of the dry storage area revealed, a 32-ounce bottle of liquid smoke that was opened, undated, without a top and loosely covered with plastic wrap, a one (1) gallon container of salad dressing with an expiration date of 11/8/21, a one (1) gallon container of barbeque sauce with an expiration date of 8/15/22, a 16-ounce bag of unsealed marshmallows, dated of 12/22, and a one (1) gallon container of sliced jalapeno peppers that was opened and had visible biological growth. On 4/16/23 at 11:47 AM, in an interview with the Cook, he stated all the staff are responsible for removing expired food. She stated the Dietary Aide is responsible for stocking the groceries when delivered and checking expiration dates	F 812	2. All residents who consume an oral diet have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Dietary Manager in-serviced all dietary staff regarding proper food storage and assigned specific staff roles to audit storage of food items daily on 4/19/2023.The Administrator also in-serviced all dietary staff from 4/20/23-5/3/2023 regarding proper food storage. 4. To monitor the performance of our corrective action and to ensure sustainability, the Dietary Manager will observe food procurement, storage, preparation, and serving 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper food sanitation. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 812	Continued From page 11 prior to putting them on the shelves. On 4/18/23 at 12:29 PM, in an interview with the Dietary Aide, he confirmed he is responsible for checking expiration dates as he receives the food from the delivery truck but stated that all staff should check for expired foods. On 4/18/23 at 12:35 PM, in an interview with the Dietary Manager (DM), he revealed all staff are responsible for checking for expired foods and removing them from the shelves, as expired foods could cause foodborne illnesses. The DM also noted that when foods are opened, they should be dated and discarded according to their facility policy, which referenced the Food and Drug Administration (FDA) Food Code. On 4/19/23 11:18 AM, in an interview with the Administrator, she stated dietary staff should put "opened dates" on food items as they are opened and make sure they are properly sealed when they are placed on the shelves. The Administrator revealed the Cook and Assistant Cook should read the labels as they pull foods from the shelves and check expiration dates, as expired foods, if contaminated, could lead to foodborne illnesses. The said she expected all dietary staff to make rounds, clean the department, and remove expired foods from the shelves.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		5/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 880	Continued From page 12	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 880	Continued From page 13 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and facility policy review, the facility failed to prevent the possible spread of infection when a nurse flushed and administered a medication via a percutaneous endoscopic gastrostomy (peg) feeding tube without wearing gloves for one (1) of three (3) residents reviewed with peg feeding tubes. Resident # 64. Findings Include: A record review of the facility's policy, "Policies and Practices-Infection Control", dated 11/1/17, 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 mange	F 880	1. Resident #64 was assessed 4/19/23 by the Director of Nursing for an infection secondary to improper percutaneous endoscopic gastrostomy (PEG) tube administration without the use of gloves. Licensed Practical Nurse (LPN) #1 was in-serviced on 4/20/23 by the Assistant Director of Nursing regarding infection prevention during PEG care and administration. All residents with PEGs were assessed on 4/20/23 by the Director of Nursing with no complications noted. 2. All residents who have a PEG have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

(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 880	Continued From page 14 transmission of diseases and Infection ..." On 04/16/23 at 12:41 PM, during an observation and interview, Licensed Practical Nurse (LPN) #1 was in Resident #64's room using a syringe and water to flush his peg feeding tube. LPN #1 was touching the resident's feeding tube, container of water, and syringe with ungloved hands. She flushed the tube and then administered a liquid medication that she identified as Acidophilus. On 04/16/23 at 01:00 PM, in an interview with LPN #1, she explained that she usually wears gloves when flushing and administering medications through a peg feeding tube. She stated she should wear gloves to protect the resident and herself and that her actions could spread germs to the resident. On 04/19/23 at 09:20 AM, in an interview with the Director of Nursing (DON), she stated LPN #1 should have applied gloves before flushing the tube because it was "standard practice" and Resident #64 could get multiple infections. A record review of the "Admission Record" revealed the facility admitted Resident #64 on 2/1/23 and had diagnoses including Cerebral Infarction and Gastrostomy Status. Record review of the "Order Summary Report" with "Active Orders As Of: 04/19/2023" revealed Resident #64 had a Physician's Order, dated 2/4/23, for "Lactobacillus (Acidophilus) Oral Capsule ...Give 2 capsule via PEG-Tube three times a day ..."	F 880	3. To ensure that the deficient practice does not recur, the Director of Nursing/Assistant Director of Nursing in-serviced all Licensed Nurses on proper PEG administration from 4/20/23-5/5/2023. The Director of Nursing will assess, with return demonstration, each licensed nurse performing PEG administration by 5/12/23. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will review a nurse on each medicaton cart performing PEG administration 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper delivery of PEG tube site care. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	