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	255105	A. BUILDING _____ B. WING _____	C 06/22/2023

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DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #21495 at the facility from 6/19/23 through 6/22/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F558, F565, F584, F623, F625, F656, F677, F689, F690, F725, F761 and F880. The SA found the facility to not be in compliance related to CI MS #21495 and cited F565, F677, F 689, F690 and F725. The census at the time of the survey was 94 and the facility was licensed for 120 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to maintain call lights within reach of the resident for two (2) of twenty-six residents reviewed. Residents #6 and Resident #20 Findings include: Review of the facility policy titled, "Call Lights: Accessibility and Timely Response", undated, revealed the purpose of this policy is to assure	F 558	1. On 06/19/2023 upon notification the call light was readjusted and secured within reach of the resident. On 06/21/2023, the call ligt was replaced with an adaptive call light to assure Residennt #6 is able to utilize the call light. 2. All residents have the potential to be affected by this practice. 3. On 06/26/2023, the Administrator,	8/4/23

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

Electronically Signed | 07/11/2023

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F 558	Continued From page 1 the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow the residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy explanation and compliance guidelines reveal each resident will be evaluated for unique needs and preferences to determine special accommodation that may be needed in order for them to utilize the call system. Call light is within reach of the resident and secured as needed. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Resident #6 An observation and interview on 06/19/23 at 10:52 AM, with Licensed Practical Nurse (LPN) #4 revealed Resident #6 in bed. The call light was on the floor by the bed. He stated he can use his call light if it is where he can reach it, but that it falls on the floor a lot. LPN #4 placed the call light within the resident's reach and confirmed he could not reach the call light and that it should be always within reach. An observation and interview, on 06/19/23 at 12:45 PM revealed Resident #6 stated he was wet. The SA asked the resident to put his call light on. The resident's call light was on the floor beside the bed. CNA #3 confirmed the call light was on the floor. An observation and interview, on 6/21/23 at 3:00 PM with the Director of Nursing (DON) and the administrator (ADM) revealed that Resident #6	F 558	Director of Nusing conducted an audit of call lights to assure the call light can be secured in reach of the resident with a clip. Negative findings were addressed at that time. Beginning 06/26/2023, the Administrator and Director of Clinical Education began education with staff regarding the facility policy on Resident Rights and call light accessibility and placement. 4. Beginning week of 7/1/2023, the Administrator, Director of Nursing will conduct monitoring rounds to check call light placement three times weekly for four weeks, then weekly for eight weeks to assure call lights are accessible and secured within reach of the resident. Findings of the audit will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, then monthly for three months for review and revision if necessary.	

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F 558	Continued From page 2	F 558		

could not reach his call light that was wrapped around the top portion of his right upper side rail. Resident #6 had very spastic movements of his upper extremities and was not able to get to his call light. The Administrator (ADM) removed the call light and placed it on the bed. The resident's hand fumbled between the call light and the wrinkles in the sheet several times and was not able to pick the call light up until the ADM held the sheet down. After several attempts, the resident managed to get the call light. The DON stated that the resident needed a touch pad call light. The ADM stated that her observation was that the resident was able to use the call light once it was put within reach but was not able to initially.

Resident #20

An observation and interview on 06/19/23 at 12:30 PM, with Resident #20 revealed the call light wrapped around the quarter length side rail on the left side of the bed. The side rail was raised up to accommodate his overbed table for the lunch meal. The resident stated he could not reach his call light and demonstrated to the State Agency (SA) that he could not reach it.

An observation and interview, on 06/21/23 at 2:53 PM with Resident #20 revealed that he stated he cannot always reach his call light, that he has stiff straight fingers and had difficulty reaching his call light that was tied around the left upper bed rail. After two (2) attempts he had to let the head of the bed down to be able to reach it. He stated that when he can't reach it, he just must wait for somebody to come in the room.

On 6/21/23 at 3:30 PM, an observation and interview with the Director of Nursing (DON) and

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F 558	Continued From page 3 the Administrator (ADM) confirmed it was difficult for Resident #20 to reach his call light where it was placed and stated it should be clipped to the bed. The DON moved the call light to the resident's lower chest area and clipped it to the sheet. The resident confirmed that it would easier to reach there. Record review of the Admission Record for Resident #20 revealed an admission date of 7/5/21 with diagnoses that included Nontraumatic Intracerebral Hemorrhage, Weakness, and other Reduced Mobility. Record review of the MDS with an ARD of 5/29/23 revealed a BIMS score of 11 which indicated Resident #20 had moderately impaired cognition. Record review of an in-service training record revealed CNA #2 and CNA #3 attended an in-service on 3/2/23 concerning call lights.	F 558		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		8/4/23

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F 565	Continued From page 4 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and facility policy review the facility failed to resolve a resident grievance in a timely manner for five (5) of 17 residents reviewed for unresolved grievances in the resident council meeting. Resident #26, 38, 51, 55 and 80 Findings Include Review of the facility policy titled, "Customer Concern Grievance Policy" with a revision date of July 2018 revealed under "Purpose ...Support each customer's (patient's/resident's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately	F 565	1. On 6/26/2023, the Administrator interviewed Resident #51, Resident #55, and Resident #80 regarding missing clothing items.. Resident #55 denied having missing items. Resident #80 reported previously missing a compression sock for his stump but confirmed that it was located and returned. Resident #51 reported a pair of gray pants as missing After search completed by the Environmental Services Supervisor, missing item for Resident #51 was ordered and arrived to the facility on 7/10/2023. On 6/26/2023, the Director of clinical	

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F 565	Continued From page 5 apprised of its progress toward resolution. The goal is to encourage open communication of customer concerns in an environment free from reprisal, retaliation, or discrimination. We have a commitment to customer service and have systems in place to address concerns. Our Grievance Official is the center Administrator. The Grievance Officials contact information, including phone number and email address, will be readily available to any resident or family member who request it." During the resident council meeting held 6/20/23 at 2:30 PM with 17 residents in attendance, it was revealed by five resident's that when they have a grievance voiced in resident council they do not always hear back about the progress for solutions. Five residents revealed that staff still take a long time to answer call lights and there is still missing clothing that has not been replaced or found. All resident's agreed that these things had been discussed on numerous resident council meetings. Resident #55 revealed he has had Certified Nurse Assistants (CNA's) come in his room, turn his light off, tell him they would be back, but never come back. He revealed he has complained about this to staff and in previous resident council meetings, but it had not got any better. Resident #38 agreed with Resident #55 and stated that he had to lay in urine for an hour and a half before because they had done that to him but had no negative outcome. Resident #51, Resident #80 and Resident #26 agreed that staffing on 3 PM-11 PM and 11 PM-7 AM were slow to answer the call lights. Resident #55, Resident #80 and Resident #51 revealed they had missing articles of clothing that had not been found or replaced and they had complained about this on several occasions. These complainants	F 565	Education and Director of Nursing began an audit of resident regarding call light response time. Negative variances noted and staff education initiated at that time regarding call light response time. On 6/26/2023, the Administrator and Activity Director began interviewing residents to determine if additional concerns regarding missing items were reported. Three residents reported missing items that were subsequently located in laundry and returned. On 6/26/2023, the Administrator interviewed the Resident Council President who agreed to increase resident council meetins in frequency to every two weeks. Resident Council meeting scheduled for 7/15/2023. 2. All residents have the potential to be affected by this practice. 3. Systemic corrections to avoid this deficient practice from reoccurring include education by the Administrator and Director of Clinical Education to all staff beginning the week of 6/26/2023 regarding the facility Grievance Process and Resident Rights. 4. Beginning the week of 6/26/2023, the Social Services Director will report new and unresolved grievances five times weekly during the morning meeting. Reporting will occur five times weekly for four weeks, then three times weekly for eight weeks to assure concerns are addressed and resolved timely.	

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F 565	Continued From page 6 confirmed that they had discussed all of this in previous resident council meetings, but it had not been resolved and feel like the facility does not have enough staff on duty and that they do not answer their grievances. An interview on 6/20/23 at 3:45 PM with Social Services revealed that sometimes she or the Activities Director holds the monthly resident council meetings. She stated that if the residents have complaints, then she takes them to the Administrator to confirm that they are a grievance, if they are then she fills out a grievance form and gives it to whatever department the grievance is about. When the State Agent (SA) ask if she was the grievance officer, she stated I guess so, I'm not sure. She revealed that she realized that the complaint about staff not answering the call lights has been ongoing, but thought it was getting better. She stated she also knew that residents still complain about missing clothing. She stated the facility has had an issue at times getting the grievance form back from whatever department has it, so she thinks that is what's happened with some of these grievances not being resolved. She revealed that she held the Resident Council meeting in April 2023 and admitted she does not have a grievance form completed for the complaint of call lights not being answered. An interview on 6/21/23 at 10:00 AM, with the Administrator confirmed that the complaint of call lights not being answered is still ongoing. She revealed that they have done education and in-services with staff regarding the importance of answering the call light in a timely manner. She stated that sometimes the staff will go in the resident's room, turn off the light and tell them	F 565	Beginning 7/1/2023, the Social Services Director and Activities Director will conduct resident interviews for five (5) residents per week for eight weeks to check for reports of missing items and call light response time. Beginning in July, Resident Council meetings will increase in frequency to two times a month for two months to provide solutions to grievances, monitor call light response time and assure areas of concern that are voiced show improvement. The Administrator will monitor call light response time by means of resident interviews and observations three times weekly for four weeks, then weekly for eight weeks. Negative variances identified will be corrected immediately. Findings of interview and resident council meetings will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, then monthly for three months to evaluate the continued compliance with this corrective action.	

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they will be back if there is something they need to do that is more pressing, but then they do not go back, so we have educated on that. She confirmed that the grievance forms from the resident council meetings go to whatever department the grievance is about and they follow up on that but was not aware there was a delay in getting them back.

An interview on 6/21/23 a 3:45 PM, with the Administrator revealed that Social Services had mentioned to her before that there was a delay in getting the grievance forms back from the department heads. She stated that they talk about grievances in every stand-up meeting, and she told Social Services to start mentioning the missing grievance forms during those meetings. She confirmed that there were no grievance forms filled out for the complaints of call lights not being answered or the complaints of missing clothes that had been mentioned during the resident council meetings since 01/2023. She confirmed the facility has an issue with unresolved grievances and have had issues with the process, but they are going to work on it.

Record review of the Resident Council Meeting Minutes revealed the following:
" 01/20/23- complaint of call light response with no grievance resolution listed.
" 03/30/23- complaint of missing clothing with no grievance resolution listed.
" 04/2023- complaint of call lights not being answered or long waits per resident #38 and 55 with no grievance resolution listed.
" 05/31/23- complaint of Resident #38 complained of no response to call light and stayed in urine for four (4) hours; late slow call light response and missing clothing was

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mentioned with no grievance resolution listed.

Record review of the grievance forms for the months of 01/2023 through 06/2023 revealed there were no forms completed for the grievances from the resident council meeting minutes reviewed.

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 4/14/23 with medical diagnoses that included Unspecified Chronic Obstructive Pulmonary Disease. Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

Record review of Resident #38's Admission Record revealed the resident was admitted to the facility on 4/15/19 with medical diagnoses that included Unspecified Type 2 Diabetes Mellitus with Diabetic Neuropathy. Record review of Resident #38's MDS with an ARD of 4/6/23 revealed in Section C a BIMS score of 10, which indicated the resident is moderately cognitively impaired.

Record review of Resident #51's Admission Record revealed the resident was admitted to the facility on 9/9/22 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Record review of Resident #51's MDS with an ARD of 6/10/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact.

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F 565	Continued From page 9 Record review of Resident #55's Admission Record revealed the resident was admitted to the facility on 4/1/23 with medical diagnoses that included Chronic (Diastolic) Congestive Heart Failure. Record review of Resident #55's MDS with an ARD of 1/6/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #80's Admission Record revealed the resident was admitted to the facility on 12/15/22 with medical diagnoses that included Encounter for Orthopedic Aftercare following Surgical Amputation. Record review of Resident #80's MDS with and ARD of 4/4/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.	F 565		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, facility policy review, and record review the facility failed to provide care to maintain hygiene as evidenced by failure to provide shower, and nail care for two (2) of twenty-six residents reviewed. Resident #25 and Resident #30. Findings include: Review of the facility policy titled, "Activities of Daily Living (ADLs) revealed under, "Policy: ...	F 677	1. On 6/20/2023, Resident #30 received a shower by Certified Nursing Assistant #1. Activity of Daily Living entry for 6/19/2023 recording bath as received was corrected to reflect care as given 6/20/2023. On 6/20/2023, the Administrator in-serviced C.N.A #1 regarding the policy for Activities of Daily Living (ADL) care, bathing schedule and policy regarding documentation.	8/4/23

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F 677	Continued From page 10 Care and services will be provided for the following Activities of Daily living: 1. Bathing, dressing, grooming, and oral care;" ... Also revealed under, "Policy Explanation and Compliance Guidelines: ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." Resident #25 An observation on 06/19/23 at 10:55 AM, of Resident #25's nails revealed long nails on both hands with a brown substance underneath, fingers bent inwards toward palms and nails were impressed into the skin in the palms. An interview with Resident #25 on 6/20/23 at 2:45 PM, revealed she would like to have her nails trimmed and stated when they get long, they start digging into the palms of her hands. An observation and interview on 6/20/23 at 2:50 PM, with Certified Nurse Aide (CNA) #2 confirmed that Resident #25's nails were long with a brown substance underneath. She stated, "Yes, they do need cleaning and trimming." She revealed that the CNAs are responsible for cleaning and trimming the nails, if the resident was not a diabetic and she stated that long nails could cause skin problems to the resident's inner palms. On 6/20/23 at 2:56 PM, an observation and interview with Licensed Practical Nurse (LPN) #3 confirmed that Resident #25's nails were long, needed trimming and cleaning. She revealed the aides or nurses would be able to do nail care for	F 677	2. All residents have the potential to be affected by this practice. 3. Beginning the week of 6/26/2023, the Director of Nursing and Director of Clinical Education began in-servicing staff regarding the policy for Activities of Daily Living (ADL) care, bathing schedules and the policy regarding documentation of care. 4. Beginning 6/26/2023, the Director of Nursing conducted monitoring rounds of ten reisdents to assure ADL care completed as ordered. Monitoring rounds to occur three times a week for four weeks, then weekly for four weeks. Direct care staff, upon completion of bathing/showers, will initial care to the shower sheet. Beginning 7/1/2023, the Director of Nursing will review shower sheets weekly to assure shower/baths given. Any negative findings will be addressed at that time. Findings of monitoring rounds and audits will be brought to the Quality Assurance Performance Improvement Committee for review and recommendatons on 7/26/2023, then monthly for three months.	

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the resident as she was not a diabetic.

An interview on 6/20/23 at 3:00 PM, with the Director of Nursing (DON) confirmed that Resident #25's nails needed trimming and cleaning and that this could cause skin concerns.

Record review of Resident #25's Admission Record revealed the resident was admitted to the facility on 8/28/18 with medical diagnoses that included Major Depressive Disorder, Anxiety Disorder, Dysphagia and Contracture, Right Hand.

Record review of Resident # 25's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated the resident is moderately cognitively impaired.

Resident #30

An interview with Resident #30 on 06/19/23 at 10:30 AM, revealed she has not been receiving her showers routinely. She revealed that she likes to get her shower early in the morning right after breakfast. She stated, "I'm supposed to get my shower on Monday, Wednesday, and Friday, but they (the staff) never come to take me."

An interview with Resident #30 on 6/20/23 at 3:00 PM, revealed she did not receive her shower yesterday. She revealed CNA # 1 gave her a shower today and it just depends on how busy they are whether I get more than one shower a week.

Record review of Resident #30's ADLs task for

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6/19/23 revealed that the bathing task was initialed as performed by CNA #1 at 13:38 (1:38 PM).

An interview on 6/20/23 at 3:55 PM, with Certified Nurse Aide (CNA) #1 confirmed that Resident #30 was supposed to receive a shower yesterday and confirmed that she did not give the resident a shower. The Survey Agent (SA) inquired why she was unable to give residents a shower yesterday, and she stated, "You all came in and then things got busy." SA inquired from CNA #1 whether she documented on the Activities of Daily Living (ADL) that a bath was completed yesterday, and she stated, "I really don't know." The CNA revealed she should not have documented the shower task as performed if it was not done.

An interview with the Administrator on 6/20/23 at 4:05 PM, acknowledged that the ADL bathing task for yesterday was initialed as completed by CNA #1 which indicated Resident #30 had received a shower. She revealed she spoke with CNA # 1 and the resident did not get a shower yesterday. She acknowledged that the resident should get her showers on the scheduled days.

Record review of Resident # 30's Admission Record revealed the resident was admitted to the facility on 12/26/21 with medical diagnoses that included Type 2 Diabetes Mellitus with Unspecified Complications, Essential Hypertension and Other Seizures.

Record review of Resident #30 's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/17/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident is cognitively intact.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review the facility failed to ensure the safety of resident as evidenced by failure to secure smoking materials for one (1) of 18 smokers in the facility. Resident #57. Findings include: A review of the facility policy titled, "Safe Smoking" with an effective date of November 1, 2016, revealed, "Purpose ...To maximize our ability to provide a safe environment for all residents/patients who smoke, while taking into account non-smoking residents. Procedure ...4. Staff members will monitor or obtain fire-igniting materials (matches/lighters) for the benefit of smokers at the nurses' station or other designated location... 5. Tobacco materials (cigarettes/cigars/chewing tobacco/snuff/electronic smoking devices) themselves, in addition to fire igniting materials, may have increased control or be removed if smoking policy violations have occurred or as a general safety policy for all residents..." An observation and interview on 06/19/23 at	F 689	1. On 6/19/2023, the Administrator obtained smoking items from Resident #57. 2. All residents have the potential to be affected by this practice. Administrator conducted individual interview 11 of 11 residents who smoke to assure all smoking materials secured. No further findings identified. 3. On 6/26/2023, the Administrator began in-servicing all staff regarding the facility smoking policy. 4. Beginning 6/26/2023, the Administrator will conduct interviews with residents who smoke to assure smoking materials are stored as per facility policy. The Administrator will conduct smoking rounds to assure residents do not have any smoking materials in possession. Interviews and smoking rounds will be conducted three times weekly for four weeks, then weekly for eight weeks. Any negative variances will be corrected immediately. Findings will be brought to	8/4/23

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F 689	Continued From page 14 02:55 PM, revealed Resident #57 sitting in her wheelchair, with a white plastic container in the shape of a cigarette box positioned between her legs, the State Agent (SA) inquired what the box was and Resident #57 stated my cigarettes and opened the lid and revealed a pack of cigarettes with approximately five (5) cigarettes remaining and a lighter. Resident #57 pulled out the lighter and then replaced it back in the box. She revealed she bought them with her when she was admitted, and she wasn't the only one with extra cigarettes and lighters in their rooms. An interview on 06/19/23 at 03:15 PM, Certified Nurse Aide (CNA) #4 revealed the CNAs are responsible for taking the residents out on smoke breaks and it is hard to keep an eye on the cigarettes and lighters because a lot of times the families bring them in to the residents. She revealed when we find them, we report it to the nurses or Administrator. She revealed it is just a cycle and we are doing the best we can to catch them because we are limited in what we can do. An observation and interview with the Administrator (ADM) on 06/19/23 at 03:35 PM, revealed Resident #57 sitting in her wheelchair in her room with the cigarette container on her lap. Resident #57 opened the white box which revealed a pack of cigarettes and a lighter. The Administrator confirmed that she was not supposed to have the cigarettes and lighter and they were to be kept in a locked box in the utility room. An interview on 06/20/23 at 03:30 PM, with CNA #5 revealed a lot of times the smokers will be acting up, we try to keep a handle on it but sometimes they will be wanting to light their own	F 689	the Quality Assurance Performance Improvement Committee on 7/26/2023, for review and recommendations monthly for thee months.	

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F 689	Continued From page 15 cigarette and then fuss about returning the lighter. She revealed this has been a problem. A record review of Resident #57's Admission Record revealed the resident was admitted to the facility on 05/02/2023 with diagnoses of Cerebral infarction, Malignant neoplasm of bladder, Depression, Cognitive Communication Deficit, and Weakness. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 9, 2023, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had a severe cognitive impairment.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		8/4/23

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F 690	Continued From page 16 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to provide incontinent care in a timely manner to a resident that was incontinent for one (1) of sixty seven incontinent residents. Resident #6. Findings include: An interview, on 06/19/23 at 12:45 PM, revealed Resident #6 stated that he was wet. He stated that he had not been changed since the night shift. The State Agency (SA) informed Licensed Practical Nurse (LPN) #4 the resident needed assistance. Resident #6 told LPN #4 that he was wet and not been changed since the night shift was there. LPN #4 requested Certified Nursing Assistant (CNA) #3 to assist with incontinent care. An observation, on 6/19/23 at 12:48 PM, revealed LPN #4 and CNA #3 provided incontinent care to Resident #6. The resident's brief was saturated	F 690	1. Resident #6 received incontinent care upon notification 06/19/2023 by Licensed Practial Nurse (LPN) #4 and Certified Nursing Assisstant (C.N.A) #3. Body audit conducted by the Director of Nursing (DON) on 06/19/2023, with no negative findings. On 6/19/2023, LPN #4 and C.N.A #3 received education by the Director of Nursing regarding the facility policy for ADL/incontinent care. 2. All residents have the potential to be affected by this practice. 3. Beginning 06/26/2023, the Administrator in-serviced licensed staff regarding the facility policy regarding Resident Rights and Actvities of Daily Living (ADL) care. 4. Beginning the week of 06/26/2023, the	

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F 690	Continued From page 17 with dark yellow colored urine. CNA #3 stated the resident's brief should not be that wet and that he should have already been changed. CNA #3 confirmed that she was assigned to Resident #6 and stated they get here and start checking residents and then the trays come out, so they have to stop and pass out the trays.She stated she had to help change out a mattress on a bed and that they only have two CNAs on this hall. LPN #4 stated that the resident probably needed changing earlier. LPN #4 confirmed that staying wet could cause skin breakdown. An interview on 6/21/23 at 1:30 PM, with the Director of Nursing (DON) revealed they do not have a policy on bowel and bladder, they just go by the standard of care for checking and changing every two (2) hours. She stated that not changing residents could cause skin breakdown. Record review of the facility Admission Record for Resident #6 revealed an admission date of 8/19/2010 with diagnoses that included Spastic Hemiplegia affecting left dominate side, Need for assistance with Personal Care, Generalized Muscle Weakness, and Neuromuscular Dysfunction of Bladder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident #6 was cognitively intact.	F 690	Director of Nursing/Unit Manager to conduct monitoring rounds of five residents to assure incontinent care provided to residents as ordered. Rounds to be conducted three times a week for four weeks, then weekly for eight weeks. Any negative findings will be corrected immediately. Findings of audit will be brought to the Quality assurance Performance Improvement Committee 7/26/2023 for review and revision as necessary monthly for three months.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		8/4/23

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F 725	Continued From page 18 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to provide enough staff to meet the needs of the residents for four (4) of 4 days of survey. Findings include: The facility Administrator provided a statement on 6/23/23 that the facility follows the state regulations for 2.8 staffing ratio and they do not have a policy to staff according to acuity level.	F 725	1. On 6/19/2023, Licensed Practical Nurse #4 and Certified Nursing Assistant #3 provided incontinent care to Resident #6. On 06/19/2023, the Director of Nursing conducted a body audit of Resident #6 with no noted skin concerns. 2. All residents have the potential to be affected by this practice. 3. On 6/19/2023, the Administrator	

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F 725	Continued From page 19 An interview on 06/19/23 at 12:45 PM, with Resident #6 on the A hall revealed the resident stated he was wet. He stated that he had not been changed since the night shift. An observation on 6/19/23 at 12:48 PM revealed Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #3 provided incontinent care to Resident #6. The resident's brief was saturated with dark yellow colored urine and CNA #3 stated the resident's brief should not be that wet. She stated that he should have already been changed and that they get here and start checking residents and then the trays come out, so they have to stop and pass the meal trays out. She stated she had to help change out a mattress on a bed. She stated that they only have two CNAs on this hall. LPN #4 confirmed the resident probably needed changing earlier but they did not have enough staff to do it all. An interview on 06/20/23 at 10:15 AM, with CNA #7 revealed the facility is short-staffed a lot she revealed today they had a call in which left them with only two aides for D hall. She revealed D hall is a very busy hall with a lot going on with the residents. During the resident council meeting held 6/20/23 at 2:30 PM, with 17 residents in attendance, it was revealed by five residents that staff still take a long time to answer call lights. All resident's agreed that this issue had been discussed in numerous resident council meetings. Resident #55 revealed he has had CNA's come in his room, turn his light off, tell him they would be back, but never come back. He revealed he has complained about this to staff and in previous	F 725	reviewed staffing which reflected a census of 91 with direct care Per patient day of 2.97. Interviews conducted with cognitively intact residents on the same hall as Resident #6 by the Administrator to assure no additional concerns regarding incontinent care with no further negative findings voiced. On 6/19/2023, the Administrator and Director of Nursing conducted resident interviews throughout the facility to assure no further instances of missed Activity of Daily Living care. No negative findings noted. On 6/26/2023, the Administrator provided education to the Director of Nursing, Assistant Director of Nursing, Workforce Manager, Human Resources Coordinator and Admissions regarding staffing needs and resident acuity. 4. Beginning the week of 6/26/2023, the Administrator, Human Resources Coordinator and Workforce Manager will review staffing five times a week for four weeks, then two times a week for four weeks to assure sufficient number of direct care staff scheduled and matches actual staff members clocked in to work. The process to manage call outs will require staff member notification to the Workforce Manger or the Administrator at least two hours prior to start of shift. Workforce Manager will utilize "On Shift" notification system to alert all direct care staff of shift availability. Additional notifications will be conducted by the	

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F 725	Continued From page 20 resident council meetings, but it had not got any better. Resident #38 agreed with Resident #55 and stated that he had to lay in urine for an hour and a half before because they had done that to him. Resident #51, Resident #80 and Resident #26 agreed that staffing on 3PM-11PM and 11PM-7AM were slow to answer the call lights. These complainants confirmed that they had discussed all of this in previous resident council meetings, but it had not been resolved and feel like the facility does not have enough staff on duty. An interview on 06/20/23 at 3:00 PM, with the Workforce Scheduler revealed that the facilities main issue is having trouble with call ins and staffing CNAs for the 3-11 PM shift. She stated it is just hard to find staff that would be willing to work. She revealed she has an alert system that she does by sending all the staff a text when there is a call in. She stated there are a few that will pick up an extra shift but if we can't get it covered, we do the best that we can. She revealed she is the one that decides how many aides are needed for each hall based on census and acuity of the residents. She revealed A and D halls have a heavier load since there are more bed bound residents on those halls and yesterday there were only two aides on D hall because of a call in. She confirmed that wasn't enough staff. She revealed she tries to find a replacement for the shift but is not always able to get someone to cover it. An interview on 6/20/23 at 3:45 PM, with Social Services confirmed that the complaint about staff not answering the call lights has been ongoing, but thought it was getting better.	F 725	Administrator, Director of Nursing, Charge Nurse or Workforce Manager by means of phone call or text messaging of team members directly. Any negative variances will be addressed immediately. Findings of staffing review will be brought to Quality Assurance Performance Improvement Committee on 7/26/2023 for review and recommendations monthly for three months.	

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An interview on 6/21/23 at 10:00 AM, with the Administrator confirmed that the complaint of call lights not being answered is still ongoing. She revealed that they have done education and in-services with staff regarding the importance of answering the call light in a timely manner. She stated that sometimes the staff will go in the resident's room, turn off the light and tell them they will be back if there is something they need to do that is more pressing, but then they do not go back, so we have, educated on that.

An interview on 06/21/23 at 10:25 AM, with the Human Resources (HR) Coordinator revealed the facility has done some hiring for CNA's but not all of them have stayed and there is a lot that only want to be PRN (as needed). She revealed the facility has hired 20 CNAs with 13 of them being PRN, 7 are full time but two of those are out on sick leave and four of them just started on June 15th and are still in training.

An interview on 06/21/23 at 2:30 PM, with the Administrator revealed she did have some staffing issues but have been working on getting the staffing improved and confirmed that the facility was still admitting new residents to the facility that also needed additional care.

An interview on 6/22/23 at 11:10 AM, with Certified Nurse Assistant (CNA) #6 revealed that they have been told as soon as a call light goes off to respond to the call light and see what the resident needs even if we are tied up with something. She stated that if it is not an emergency, we tell the resident we will be back as soon as possible to assist with their needs. She revealed that if they were passing trays on the halls or in the dining room it may take a little

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longer to respond.

Record review of the Resident Council Meeting Minutes revealed the following:
" 01/20/23- complaint of call light response with no resident complainant listed.
" 04/2023- complaint of call lights not being answered or long waits per resident #38 and 55.
" 05/31/23- complaint of Resident #38 complained of no response to call light and stayed in urine for 4 hours; late slow call light response was mentioned with no resident names.

Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact.

Record review of Resident #26's MDS with an ARD of 5/1/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #38's MDS with an ARD of 4/6/23 revealed in Section C a BIMS score of 10, which indicated the resident is moderately cognitively impaired.

Record review of Resident #51's MDS with an ARD of 6/10/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #55's MDS with an ARD of 1/6/23 revealed in Section C a BIMS score of 15 , which indicated the resident is cognitively intact.

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

(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 725	Continued From page 23 Record review of Resident #80's MDS with and ARD of 4/4/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.	F 725		