STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(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 a complaint investigation (CI) on 8/30/23 at the facility for CI MS #21049 related to falls and residents being left wet. The SA found the facility was in compliance related to assessments, but was found to not be in compliance with Medicare and Medicaid requirements for participation related to residents being left wet. The SA cited regulatory deficiencies at F656 and F677. The facility held a license for 152 beds and had a census of 112 at the time of the survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		9/25/23

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

Electronically Signed | 09/14/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to implement a care plan related to Activities of Daily Living (ADL) for residents who were dependent on the staff for care for two (2) of five (5) residents reviewed. Resident #3 and Resident #4. Findings include: Review of the policy titled, "Comprehensive Care Plan," with an effective date of May 1, 2012, revealed the interdisciplinary care plan is implemented to guide health care center staff in the provision of necessary care and services to obtain and maintain the highest practicable	F 656	1. Residents #3 and #4 were immediately assessed by the Assistant Director of Nursing Services on August 30, 20223. No skin breakdown or emotional distress noted. Perineal care was provided by certified nursing assistants. 1:1 education was provided to certified nursing assistants who failed to follow the care plan regarding providing necessary care every two hours on August 31, 2023 by the Assistnat Director of Nursing. Nurses responsible for assuring these residents were changed and turned were educated by the Assistant Director of Nursing on August	

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F 656	Continued From page 2 physical, mental, and psychosocial well-being of the resident and promotion of the resident and family in planning care. Resident #3 Record review of the care plan for Resident #3 with a date initiated of 12/28/21 and a revision date of 5/5/2023 revealed a focus of: I have a physical functioning deficit related to: Self-care impairment. The intervention for the focus included: I usually am dependent on staff for locomotion, dressing, toileting, personal hygiene, and bathing. Assist with turning and repositioning every two (2) hours and PRN (as needed). Record review of the Nursing Kardex for Resident #3 with a revision date of 8/8/23 revealed under toileting - Check and Change with turning schedule, Briefs. Date initiated 7/4/2023. During an observation, on 8/30/23 at 9:30 AM, revealed Resident #3 in the day room in a wheelchair with other residents. At 10:20 AM, 11:15 AM, and 11:30 AM Resident #3 remained in the same spot and had not been moved by the staff. At 11:35 AM Resident #3 was taken to the dining room for lunch and brought back to the day/TV room at 12:15 PM. During an observation and interview, on 8/30/23 at 2:30 PM with Certified Nursing Assistant (CNA) #3, during her assessment of Resident #3, confirmed that the resident needed to be changed. When the resident was turned and checked, the brief was saturated with dark yellow urine over the area of the brief covering the buttocks.	F 656	30th and August 31st, 2023. On August 30th, 2023, the Director of Nursing Services and the Assistant Director of Nursing completed assessments of all incontinent residents to determine whether there was anyone else who had not been changed and turned. No additional residents were found. 2. All incontinent residents have the potential to be affected by this deficient practice. 3 Activity of Daily Living Rounds will be completed weekly by the Director of Nursing Services and/or the Assistant Director of Nursing Services so that all residents will be rounded on during the month to verify activities of daily living needs are being met beginning on August 30, 2023. Review of all new admissions within 24 hours of admission to verify that all team members are aware of activity of daily living needs for each admission beginning on August 31, 2023. Education was provided to certified nursing assistants and nurses on August 30th and August 31st, 2023 by Assistant Director of Nursing Services regarding following the care plan in reference to turning and changing residents. 4. Audits will be completed by Director of Nursing Services and Assistant Director of Nursing Services on five residents weekly for three months beginning on August 31, 2023 to ensure that the activities of daily	

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F 656	Continued From page 3 In an interview on 8/30/23 at 2:40 PM, with Certified Nursing Assistant (CNA) #1 confirmed that she did not change Resident #3 at 10:00 AM, which would have been the two (2) hour increment for the resident to be checked for incontinence. She stated that it was because she was in the dining room and stated the residents should be checked and changed every two (2) hours. Review of the facility Admission Record for Resident #3 revealed an admission date of 12/27/21 with diagnoses that included Unspecified Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominate side, Unspecified Lack of Coordination, and Aphasia. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated Resident #3 was unable to complete the interview. Resident #4 Record review of the Nursing Kardex for Resident #4 with an initiation date of 7/13/2023 revealed under toileting to check and change with turning schedule, Briefs. Record review of the care plan for Resident #4, with an initiation date of 3/23/23, revealed a focus of: I have a self-care deficit related to impaired cognition/dementia with an invention to check, change, and reposition every two (2) hours and as needed and provide peri care after each incontinent episode.	F 656	living care plans are being followed. Findings of audits will be addressed in Quality Assessment and Performance Improvement Committee for a minimum of three months by the Director of Nursing or Assistant Director of Nursing Services for review and interventions as necessary beginning with September Quality Assurance Performance Improvement Meeting on September 21, 2023.	

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F 656	Continued From page 4	F 656		

Record review of the care plan included a focus with an initiation date of 11/01/2022 and a revision date of 6/27/23 for Alteration in elimination of bowel and bladder incontinence. I have irritable bowel syndrome (IBS). The interventions included provide assistance to toilet and use briefs/pads for incontinence protection. Observe frequency/timing of incontinence episodes.

On 8/30 23 at 9:30 AM, an observation revealed Resident #4 sitting in a wheelchair in the day room. An observation, at 11:10 AM revealed Resident #4 in her room visiting with her "caretaker" who stated she comes to check on her every morning. An interview with the caretaker/visitor who pushed the resident back to the day room revealed that no one had changed the resident while she has been here visiting.

An observation and interview, at 11:30 AM revealed Resident #4 remained in the day room until 11:42 AM when she was pushed into the dining room. At 12:30 PM Resident #4 was returned to the day room by CNA #2 who confirmed she was assigned to the resident today.

During an interview, with CNA #2 on 8/30/23 at 2:50 PM revealed that she was doing showers at 10:00 AM and saw the "caregiver" for the resident visiting with her. She stated that they sometimes change the resident, but she did not check with them about that today. CNA #2 confirmed that it is her responsibility to make sure residents are checked and changed. She stated, "She dropped the ball today." She stated that not changing residents could cause rash or skin breakdown

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F 656	Continued From page 5 and confirmed that she had not changed the resident since she was gotten up this morning. In an interview, on 8/30/23 at 3:15 PM, concerning residents not being changed, the Director of Nursing (DON) stated that was not good quality of care and that is was not the standard of care. She stated that not changing residents could cause skin breakdown and her biggest concern was pressure sores. The DON confirmed that both residents had a care plan in place for incontinence. She confirmed that the care plan was not followed. She stated the purpose of the care plan is that it teaches the staff how to care for the patient (resident) and what their needs are. Record review of the facility Admission Record for Resident #4 revealed an admission date of 10/18/2022 with diagnoses that included Alzheimer's Disease and Unspecified Urinary Incontinence. Record review of Section C the MDS with an ARD of 7/10/23 revealed a BIMS score of two (2) which indicated Resident #4 had severe cognitive impairment.	F 656		
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 observation, staff and visitor interview, and facility policy review the facility failed to	F 677	1. Resident #3 and #4 were immediately assessed by the Director of Nursing and	9/25/23

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F 677	Continued From page 6 provide timely incontinent care for two (2) of five (5) residents reviewed. Resident #3 and Resident #4. Findings include: Review of the facility policy titled, "Incontinence", undated, revealed based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines revealed the facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. Resident #3 An observation, on 8/30/23 at 9:30 AM revealed Resident #3 in the day room in a wheelchair with other residents. An observation at 10:20 AM, 11:15 AM, and 11:30 AM revealed Resident #3 in the same spot. At 11:35 AM Resident #3 was taken to the dining room for lunch and brought back to the day room at 12:15 PM. At 12:30 PM she was taken to her room for care. An observation and interview, on 8/30/23 at 2:30 PM with Certified Nursing Assistant (CNA) #3, during her incontinent care check of Resident #3, she confirmed that the resident needed changing. The resident was turned and checked, and the brief was saturated with dark yellow urine over	F 677	Assistant Director of Nursing for incontinence or complications on August 20, 2023. Residents were provided peri care and barrier cream. No negative findings were observed. The resident care plans were reviewed and updated. Beginning on August 30, 2023, Certified Nurse Assistant Kardex's were reviewed to assure that every two hour incontinence care was addressed by the Director of Nursing and Assistant Director of Nursing. The Director of Nursing/Assistant Director of Nursing immediately completed assessments of all incontinent residents to determine if any other residents were soiled or wet. No additional residents were found. Certified Nurse Assistants #1 and #2 received 1:1 education from Assistant Director of Nursing on August 31, 2023, regarding providing incontinence care when wet, checking every two hours or sooner, and customer service. The Assistant Director of Nursing administered a competency evaluation on peri-care and education on abuse and neglect to these Certified Nurse Assistants on August 31, 2023 prior to them returning to the floor to care for patients. 2. All incontinent residents have the potential to be affected by this deficient practice. 3. Education was initiated on August 30, 2023 for nursing staff by the Assistant Director of Nursing regarding the standard of care to include rounding every two hours and providing incontinence care	

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F 677	Continued From page 7 the area of the brief covering the buttocks. An interview, on 8/30/23 at 2:40 PM with CNA #1 stated that she had not changed the resident because she was in the dining room. She confirmed the residents should be checked and changed every two (2) hours and confirmed that the resident had not been changed since she was gotten up this morning. Record review of the facility Admission Record for Resident #3 revealed an admission date of 12/27/2021 with diagnoses that included Unspecified Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominate side, Unspecified Lack of Coordination, and Aphasia. Record review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated Resident #3 was unable to complete the interview. Resident #4 An observation at on 8/30/23 at 9:30 AM, revealed Resident #4 sitting in a wheelchair in the day room. An observation on 8/30/23 at 11:10 AM revealed Resident #4 in her room visiting with her "caretaker" who stated she comes to check on her every morning. An interview with the caretaker/visitor who pushed the resident back to the day room revealed that no one had changed the resident while she has been here visiting.	F 677	when residents are soiled or wet. All incontinent resident's care plans and Kardex will be reviewed and updated as needed to assure that incontinence is addressed by Director of Nursing and the Assistant Director of Nursing beginning on August 30, 2023. Education will be provided to staff related to abuse and neglect to include providing necessary care and services beginning on August 30, 2023 by the Assistant Director of Nursing. All Certified Nurse Assistants will successfully complete a competency evaluation on peri care beginning on August 31, 2023 by the Assistant Director of Nursing, Resident's briefs will be checked for incontinence episodes by certified nurses assistants prior to meals. The Director of Nursing and or Assistant Director of Nursing will assure that a minimum of ten incontinent residents are monitored on a daily basis to assure the certified nurse assistants are rouonding and cchanging briefs as needed before meals beginning on August 30, 2023. 4. The Director of Nursing/Assistant Director of Nursing will audit incontinence residents five times per week x one month and one time x week x two months to assure the corrective action listed is effective beginning on August 31, 2023. Findings of audits will be addressed in Quality Assessment and Performance Improvement Commitee for a minimum of three months by the Director of Nursing Services or Assistant Director of Nursing Services for review and interventions as necessary beginning with September	

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F 677	Continued From page 8 An observation, at 11:30 AM revealed Resident #4 remained in the day /TV room until 11:42 AM when she was pushed into the dining room. On 8/30/23 at 12:30 PM, an observation and interview with CNA #2 revealed Resident #4 was returned to the day room by CNA #2. CNA #2 confirmed she was assigned to the resident today. An observation, on 8/30/23 at 12:40 PM, resident was taken to her room by CNA #4. Peri care was performed and the brief was saturated with dark yellow urine and a small amount of liquid stool. CNA #4 stated that her family likes her to lay down after lunch because she gets up early on the 11-7 shift. An interview, with CNA #2 on 8/30/23 at 2:50 PM, revealed that she was doing showers at 10:00 AM and saw the "caregiver" for the resident visiting with her. She stated that they sometimes change the resident, but she did not check with them about that today. CNA #2 confirmed that it is her responsibility to make sure residents are checked and changed. She stated, "She dropped the ball today." She stated that not changing residents could cause rash or skin breakdown. During an interview, on 8/30/23 at 3:15 PM, concerning residents not being changed, the Director of Nursing (DON) stated that she was appalled because that was not good quality of care and not a good standard of care. She stated that not changing residents could cause skin breakdown and her biggest concern was pressure sores. She revealed that residents have family and visitors come in and check on them and do their hair, but if they are our patient	F 677	Quality Assurance Performance Improvement Meeting on September 21, 2023.	

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F 677	Continued From page 9 (resident), we (staff and CNA's) should be checking and changing the residents who are incontinent. Record review of the facility Admission Record for Resident #4 revealed an admission date of 10/18/2022 with diagnoses that included Alzheimer's Disease and Unspecified Urinary Incontinence. Record review of Section C the MDS with an ARD of 7/10/23 revealed a BIMS score of two (2) which indicated Resident #4 had severe cognitive impairment.	F 677		