STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Tylertown	200 Medical Circle Tylertown, MS 39667

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observation, interviews, record review, and policy review the facility failed to provide perineal care in a manner to prevent the possibility of urinary tract infection for one (1) of four (4) residents reviewed for incontinent care. (Resident #5) Findings include: On 09/04/24 at 3:03 PM, during an observation of Certified Nurse Aide (CNA) #1 as she provided perineal care for Resident #5, the CNA assisted the resident to turn on her side to complete her perineal care. The CNA wiped the resident from the back to front, instead of front to back, a total of five (5) times. On 09/05/24 at 9:36 AM, in an interview with CNA #1, she stated she did not do the perineal care on the buttocks correctly. She stated she wiped back to front. She stated she should have wiped front to back. She stated her actions could cause the resident to develop a urinary tract infection (UTI). She stated she has been a CNA for [AGE] years and has had training on perineal care. On 09/05/24 at 9:45 AM, in an interview, the Director of Nursing (DON) stated CNA #1 should have wiped front to back when she provided perineal care. She stated the CNA's actions could increase the risk of infection. Review of Admission Record for Resident #5 revealed the facility admitted the resident on 12/13/21. The resident's diagnoses included Chronic Kidney Disease and Dementia. Review of the Quarterly Minimum Data Set (MDS), for Resident #5, with an Assessment Reference Date (ARD) of 6/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident had severe cognitive impairment. Section GG revealed the resident required substantial/maximal assistance with toileting hygiene.

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.

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50751 Based on observation, interviews, record reviews and facility policy reviews the facility failed ensure tube feedings were administered as ordered for one (1) of seven (7) residents who recieve enteral feedings. (Resident #1) Findings include: Review of the facility policy titled, Enteral Nutrition, dated 8/1/12 revealed, It is the policy of this facility to ensure that a nutritional assessment is completed for all residents receiving enteral feeding. Orders will reflect specific content to assure quality of enteral delivery .2.The tube feeding order will be recorded. The following information should be included in the diet order or comments section: . e. amount (c.c.s) of formula to be given for each feeding and total c.c.s to be given per 24 hours . On 9/3/24 at 10:48 AM, an observation revealed Resident #1 lying in bed with his PEG (Percutaneous Endoscopic Gastrostomy) tube feeding formula attached to an electronic pump. Jevity 1.5 was infusing per pump at the rate of 70 ml/hr. (milliliters/ per hour). On 9/3/24 at 2:19 PM, in an attempt to verify the physician orders regarding the infusion rate of Resident #1's tube feeding in the resident's electronic chart, the orders were not available. There were orders regarding the flushing and care of the PEG tube, but no order available for review for the rate and type of feeding the resident was to receive. On 9/3/24 at 2:23 PM, in an interview with the Director of Nurses (DON), she was unable to locate the order when asked for a printed copy of the tube feeding orders for Resident #1. At that time, the DON stated that there had recently been an electronic update to their charting system and that she would check the MAR (Medication Administration Record). On 9/3/24 at 2:37 PM, the DON reported that within the electronic system, there were no current active orders for Resident #1's tube feeding rate or type of feeding to be administered. During an observation, interview and record review at 2:57 PM on 9/3/24, the DON provided an updated print out of Resident #1's Order Summary Report, with active orders as of 8/14/24, in which the order had been corrected to include the resident's tube feeding order that included the type and rate of feeding the resident had been receiving since the initial order written on 1/25/16. The DON observed and confirmed the tube feeding was now infusing with Jevity 1.5 @ 75 ml/hr. as ordered. Further review of the order revealed that the physician's order included a time frame for the infusion in which the resident was to receive the feeding for 18 hours per day from 6:00 AM until 12 MN (midnight) A record review of the Admission Record for Resident #1 revealed that the facility admitted the resident on 6/6/2008. The resident's diagnoses included Dysphagia, Aphasia, and Unspecified Intellectual Disabilities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47873 Based on observation, staff interview, and facility policy review, the facility failed to prevent the possible transmission of diseases and infections by storing clean durable medical equipment (DME) in a room marked for biohazard materials for two (2) of three (3) days of survey. Findings include: Review of the facility's, Policies and Practices - Infection Control, dated 11/1/2017, 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 manage the transmission of diseases and infections . On 9/3/24 at 11:27 AM, in an observation of the biohazard room and interview with Maintenance #1, revealed the room was clearly marked as a biohazard area. Inside the room, a biohazard container with a red bag was placed on the right side, while oxygen concentrators, covered in plastic bags, were located on the left side of the room. Maintenance #1 stated the oxygen concentrators were considered clean since they were bagged, though he acknowledged the room was marked as a biohazard area. In a subsequent observation and interview on 9/4/24, at 9:41 AM, with Registered Nurse (RN) # 1 the same biohazard room was observed. On the right side, the biohazard container with the red bag was still present, while on the left side, the oxygen concentrators with plastic coverings remained. Additionally, an unclean bedside commode was placed on top of the concentrators. RN #1 acknowledged that while the biohazard room was technically considered dirty, she believed the concentrators were clean because staff had cleaned and bagged them. On 9/4/24 at 9:59 AM, in an interview with the Director of Nursing (DON), she revealed the facility's policy and practices were intended to facilitate maintaining a safe, sanitary comfortable environment and to help prevent and manage the transmission of diseases and infections. She confirmed the facility to follow infection control practices by storing cleaned oxygen concentrators in the biohazard room. 50751