STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Ripley	101 Cunningham Dr Ripley, MS 38663

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, interview, record review, and facility policy review the facility failed to ensure that a comprehensive care plan was implemented for a dependent resident who was transferred via a mechanical lift using the wrong size sling which resulted in the sling breaking and causing the resident to sustain a fall with fracture for one (1) of three (3) residents reviewed. Resident #1. Based on implementation of corrective actions completed on 8/30/24 prior to the State Agency (SA) entrance on 9/11/24, it was determined to be Past Non-Compliance (PNC). Findings Included: Review of the facility policy, MDS (Minimum Data Set) and Care Plans with effective date of August 2019, revealed that care plans and MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines. Record review of Resident #1's Care Plan initiated on 07/17/24 revealed that she had a physical functioning deficit with interventions that included to use a total lift with blue sling. On 09/11/24 at 8:55 AM, an observation and interview with Resident #1, revealed that she had a bad fall last month. She confirmed that on the day of the fall, there were two aides in the room to transfer her out of bed into the wheelchair using a lift. She revealed that they lifted her up off her bed, pushed the lift towards the wheelchair and as soon as she was out of reach of her bed, the strap on the sling broke and she fell to the floor. On 09/11/24 at 9:22 AM, an interview with Administrator (ADM) revealed that on 08/21/24, the staff came to his office and reported that Resident #1 fell from the lift sling to the floor. He revealed that the right shoulder strap on the sling broke while Resident #1 was in it during a transfer from her bed to her wheelchair. ADM revealed that the Certified Nursing Assistants (CNA) used the green sling with Resident #1 and confirmed that the CNAs did not use the bariatric sling which was safe up to 750 pounds. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	On 09/11/24 at 1:40 PM, an interview with CNA #1, revealed that on 08/21/24, she and CNA #2 had gotten Resident #1 in the sling, raised her up to get her in the wheelchair. She revealed that when they raised her up over the bed and moved the lift towards the chair, the right shoulder strap on the sling snapped and Resident #1 fell to the floor and landed on her right shoulder. CNA #1 revealed that they used the green lift sling because that's the one they had always used with her. She stated, We went along with everyone else. CNA #1 revealed that they realized that she was supposed to be in the extra large blue lift sling because of her weight but they didn't know this until after the fall. She revealed that they were supposed to look in the Kiosk to find out which sling to use. She stated, We felt terrible about it. CNA revealed that Resident #1 had always been in a green sling and they (CNAs) did what everyone else was doing. She revealed that they should have gone to the Kiosk and seen what sling was on her care plan to use. She said, This really upset me because I have always tried to do the right thing and I was just not aware that her care plan stated something different. On 09/11/24 at 2:35 PM, a phone interview with CNA #2, revealed that on 08/21/24, she and CNA #1 were getting Resident #1 up for an activity. She revealed that they got her ready, positioned her in the green sling and moved the lift off of the bed to move towards her wheelchair. She revealed that as soon as they cleared the bed with her, the right shoulder strap on the green sling snapped and Resident #1 fell to the floor. CNA #2 revealed that they always used the green sling with Resident #1 like everyone else did but said they should have used the extra-large blue sling that was care planned. CNA #2 revealed that they should have looked it up in their computer system before they grabbed the green sling because the type of sling to use was care planned. She revealed that the care plan also included what care needed to be done for each resident. She stated, I will definitely look at the Kardex from now on. On 09/11/24 at 3:15 PM, an interview with MDS Coordinator, revealed that the purpose of the care plan was to set up what individualized care was needed for each resident, so the staff knew how to provide for them. She revealed that the care plans were specific to each resident and should be followed by all staff members. MDS Coordinator confirmed that Resident #1's care plan related to the hoyer lift was not followed when the CNAs used the green sling instead of the blue sling that was care planned and it resulted in a fall with injury. Record review of Resident #1's Lift Transfer Evaluation dated 05/28/24 revealed that a total lift was required and the sling size marked to use was the extra large blue sling which had weight ranges of 275 lbs - 500 lbs Under Total Lift Required section of the Lift Transfer Evaluation was documented, Focus: I have a physical functioning deficit with transfers and require assistance of Intervention: Hoyer Total Lift XLarge (Blue) Sling Record review of the Lift Transfer Evaluation also revealed that the Large green sling weight ranges were 175 lbs - 300 lbs. Record review of Resident #1's Weight Summary revealed that she weighed 376.3 pounds on 08/08/24. Record review of Resident #1's Admission Record revealed an admitted [DATE] and had diagnoses that included Morbid (Severe) Obesity, Type 2 Diabetes Mellitus, and Need for Assistance with Personal Care. Record review of Resident #1's MDS with Assessment Reference Date (ARD) of 09/08/24 under Section C revealed a Brief Interview for Mental Status Score of 15 which indicated that she was cognitively intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review revealed the following measures were taken and plans put in place to correct the deficient practice prior to the State Agency's (SA) entrance into the facility on [DATE]: Resident #1 was assessed by Nurse Practitioner immediately after the fall and was sent out to the emergency roiagnom on [DATE]. Lift was inspected on 08/22/24 following the incident with no identified concerns by Maintenance. The lift and sling involved in the accident were removed from the floor by Administrator and remained out of service immediately on 08/21/24. All lifts and slings were assessed by the for any disrepair on 08/21/24 by Administrator and four yellow slings, one blue sling and one green sling were removed due to being worn, and in ill repair. New replacements were ordered on 08/26/24. New lift slings arrived on 08/29/24, they were numbered, dated, and put in service. The Kardex was reviewed for all residents for appropriate lift and sling use on 08/22/24 by the Director of Clinical Education (DCE). CNA #1 and CNA #2 were educated on proper lift and sling use and return demonstration was completed on 08/21/24 by the DCE. Checkoffs were completed by the DCE with all staff which were initiated on 08/21/24 and continue throughout all shifts until everyone completed. New Lift Transfer assessments were completed by the ADON on all current residents and care plans were updated on 08/22/24. Therapy referrals were made as needed by the ADON on 08/22/24 for anyone who required a lift and lift sling. Care Plans and Kardex updated as needed on 08/22/24 by the ADON. Team huddles with lift/transfer education completed 08/21/24 - 08/22/24 by the DCE. State Agency, Ombudsman, and Attorney General (AG's) office notified on 08/22/24 by Director of Nursing. In-Service on Lift/Transfer Program and Transfer Belts, Abuse/Neglect/Exploitation, and Elder Justice Program were completed by the DCE for all staff members with 100% compliance on 08/21/24 - 08/23/24. Topics included: Performance of lift usage, inspecting the sling prior to use, laundering slings and where to find them, and on the Kardex - only using care planned sling colors. In-Services initiated on 08/23/24 with Housekeeping and Laundry Manager on sling inspection and guidelines by the DCE. Hoyer Lift Policy and Procedures were reviewed with CNA #1 and CNA #2 and all other staff beginning on 08/21/24-08/22/24 by the DCE. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Audits on all Lift Assessments were completed on 08/21/24 and are on-going by the ADON. Quality Assurance and Performance Improvement (QAPI) meeting was held on 08/30/24 and all required staff members were in attendance. Plan to continue the weekly audits and bring results to the monthly QAPI meetings for three (3) months.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interview, record review, and facility policy review the facility failed to ensure the safety of a dependent resident during a lift transfer by using the wrong lift sling resulting in a strap on the sling breaking. Resident #1 fell to the floor and sustained fractures as a result of the fall for one (1) of three (3) residents reviewed for falls. Resident #1 Based on implementation of corrective actions completed on 8/30/24 prior to the State Agency (SA) entrance on 9/11/24, it was determined to be Past Non-Compliance (PNC). Findings Included: Review of the facility policy, Lift 4 Care - Safe 4 All dated May 2024, revealed under guideline, 7. In order to maintain patient's and residents' safety, patients and residents should be lifted or transferred by the lift and sling which is deemed appropriate after the lift evaluation is completed. There should be no interchanging of lifts and slings . Record review of the Investigation of Resident #1's fall revealed that on 08/21/24 at 2:00 PM, Resident #1 had a fall with injury in her room. The incident was reported to Resident #1's representative, her daughter. Resident #1 experienced a witnessed fall with two witnesses, Certified Nursing Assistant (CNA) #1 and CNA #2. Interviews with CNA #2 revealed the fall occurred during an active staff transfer from bed to wheelchair for Resident #1 to attend activities. CNA #2 revealed that during the transfer, Resident #1's right shoulder strap disconnected from the sling which caused immediate fall to floor with resident landing on right side. Staff did witness Resident #1 hitting her head with complaints expressed from resident of right shoulder and left hip pain. CNA #1 revealed through investigative interview that while transferring Resident #1 from bed to chair, resident was up in the lift, the lift was guided to the middle of the room, before the wheelchair could be placed under her, the upper right strap broke and the resident fell to the floor, landing on her right side. Record review of the Emergency Department (ED) notes dated 08/21/24-08/22/24 revealed, the right lower extremity is shortened, externally rotated and tender to movement. Left hip x-ray and computed tomography scan (CT) revealed a comminuted mildly displaced left intertrochanteric femur fracture deformity. Resident #1 was transferred from the local ED to a hospital for surgical repair of the fracture. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/11/24 at 8:55 AM, an observation and interview with Resident #1, revealed her lying in her bariatric bed in her room. She had bruising to her right upper arm and shoulder and a healing surgical site to her left leg. Resident #1 was morbidly obese. Resident #1 revealed that she had a bad fall last month. She revealed that there were two aides in the room to transfer her out of bed into the wheelchair using a lift. She revealed that they lifted her up off her bed, pushed the lift towards the wheelchair and as soon as she was out of reach of her bed, the strap on the sling broke and she fell to the floor. Resident #1 revealed that she fell face down on the floor, she heard a loud pop and stated, It hurt so bad. She revealed that the nurses and nurse practitioner came immediately to her room, checked her out, called the ambulance and she went to the hospital. She confirmed that she had to have surgery and that her staples were removed yesterday and stated that she was still in pain, but it was much better. On 09/11/24 at 9:05 AM, an interview with Licensed Practical Nurse (LPN) #2, revealed that she worked the day of Resident #1's fall but was not in the room when it happened. LPN #2 revealed that she heard a scream for help from down the hall and that when she entered Resident #1's room, she found her lying with her head on the floor at the foot of her roommate's bed and Resident #1 was positioned on her right side. LPN #2 noticed that her left leg was shorter than her right leg and that she was screaming for help and complaining of pain. LPN #2 revealed that the nurse practitioner came immediately into her room, checked her out, and they called for an ambulance. LPN #2 revealed that Resident #1 complained of pain to her right arm, right shoulder and left leg. LPN #2 revealed that Resident #1 went out to the hospital, had surgery and was back at the facility about a week later and stated that this was very traumatic for her. On 09/11/24 at 9:22 AM, an interview with Administrator (ADM), revealed that on 08/21/24, the staff came and got him when Resident #1 fell from the sling. He revealed that the strap on the sling broke while Resident #1 was in it during a transfer from her bed to her wheelchair and she fell to the floor. ADM revealed that he reported this to the lift manufacturer, they inspected the lift and found nothing wrong with it. ADM revealed that the laundry staff inspected the slings every time they go to laundry and if they looked ragged out they discarded them. He clarified that ragged out meant that the material on the sling was worn thin, tattered or torn or if the straps were in disrepair. ADM confirmed that they used the green sling with Resident #1, and that the Certified Nursing Assistants (CNAs) did not use the bariatric sling which was safe up to 750 pounds. ADM revealed that Resident #1 was sent to the hospital and was found that she had a fractured hip and fractured femur. ADM revealed that they started an immediate investigation and reported the witnessed fall. He revealed that this was an unfortunate accident, and he hated it for the resident. On 09/11/24 at 9:35 AM, an interview with Family Nurse Practitioner (FNP), revealed that she was in the facility working on the day that Resident #1 fell from the lift, on 08/21/24. She stated that the staff came and got her when it happened, and she went and immediately assessed the resident. FNP revealed that Resident #1 was stunned, and she complained of left leg and hip pain. FNP revealed that she observed that her left leg was externally rotated and was shorter than her right leg. She revealed that the ambulance arrived within a couple of minutes, they gave her some pain medication and transported her to the hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/11/24 at 10:00 AM, an interview with Director of Clinical Education (DCE), revealed that each specific sling had weight ranges to go by and that the blue sling was for bariatric residents up to 750 pounds. She revealed that the green sling shouldn't have been used with Resident #1, the CNAs should have used the blue sling. DCE revealed that the slings were inspected as they came through the laundry department, but she had educated the CNAs to inspect them prior to use as well to prevent other incidents. On 09/11/24 at 12:15 PM, an interview with Assistant Director of Nursing (ADON), revealed on 08/21/24, that CNA #1 and CNA #2 were transferring Resident #1 using a lift and one of the straps on the sling broke and she fell to the floor. ADON verified that the guidelines on the proper lift sling use on the Lift Assessments for Resident #1 revealed that the green sling was a size large, and its weight ranges were 175 - 300 pounds and the blue sling was an extra-large and it's weight ranges were 275 - 500 pounds. ADON confirmed that the blue sling was care planned to be used with Resident #1 and the green sling should not have been used. On 09/11/24 at 1:40 PM, an interview with CNA #1, revealed that on 08/21/24, she and CNA #2 had gotten Resident #1 in the sling and raised her up to get her into the wheelchair. She confirmed that when they raised her up over the bed and moved the lift towards the chair, the right shoulder strap on the sling snapped and Resident #1 fell to the floor and landed on her right shoulder and was in pain. CNA #1 revealed that they used the green sling because that's the one they had always used. She stated, We went along with everyone else. CNA #1 revealed that they realized that she was supposed to be in the extra-large blue sling because of her weight but they didn't know this until after the fact. She revealed that they were supposed to look it up in the Kiosk to find out which sling to use. She stated, We felt terrible about it. CNA #1 revealed that Resident #1 had always been in a green sling and she did what everyone else was doing. She revealed that they should have gone to the Kiosk and looked up what sling was on her care plan to use. She said, This really upset me because I have always tried to do the right thing and be diligent with these residents. On 09/11/24 at 2:35 PM, a phone interview with CNA #2, revealed that on 08/21/24, she and CNA #1 were getting Resident #1 up for an activity, that they got her ready, positioned her in the green sling and moved the lift off of the bed to move towards her wheelchair. She revealed that as soon as they cleared the bed with her, the strap snapped, and she fell to the floor. CNA #2 revealed that the green sling was always used with Resident #1. She confirmed that they should have used the blue sling that was care planned, they just followed suit and did what everyone else was doing. CNA #2 revealed that the Kardex told them which sling to use and what care was needed to be done for each resident. She stated, I will definitely look at the Kardex from now on. Record review of Resident #1's Lift Transfer Evaluation dated 05/28/24 revealed that a total lift was required, and the sling size marked to use was the extra-large blue sling which had weight ranges of 275 pounds (lbs.) - 500 lbs. Total Lift Required section was documented, Focus: I have a physical functioning deficit with transfers and require assistance of .Intervention: Hoyer Total Lift XLarge (Blue) Sling Record review also revealed that the Large green sling weight ranges were 175 lbs. - 300 lbs. Record review of Resident #1's Weight Summary revealed that she weighed 376.3 pounds on 08/08/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Progress Note dated 08/21/24 completed by Family Nurse Practitioner, revealed, complains of left hip and leg pain. Hit back of head on wheel of roommate's bed. Near Syncope after fall, difficulty breathing immediately following fall, 02 (oxygen) applied via mask. LLE (left lower extremity) with external rotation and LLE shortened compared to RLE (right lower extremity). Record review of Resident #1's Admission Record revealed an admitted [DATE] and diagnoses that included Morbid (Severe) Obesity and Need for Assistance with Personal Care. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/08/24 under Section C revealed a Brief Interview for Mental Status Score of 15 which indicated that she was cognitively intact. Record review revealed the following measures were taken and plans put in place to correct the deficient practice prior to the State Agency's (SA) entrance into the facility on [DATE]: Resident #1 was assessed by Nurse Practitioner immediately after the fall and was sent out to the emergency roiagnom on [DATE]. Lift was inspected on 08/22/24 following the incident with no identified concerns by Maintenance. The lift and sling involved in the accident were removed from the floor by Administrator and remained out of service immediately on 08/21/24. All lifts and slings were assessed by the for any disrepair on 08/21/24 by Administrator and four yellow slings, one blue sling and one green sling were removed due to being worn, and in ill repair. New replacements were ordered on 08/26/24. New lift slings arrived on 08/29/24, they were numbered, dated, and put in service. The Kardex was reviewed for all residents for appropriate lift and sling use on 08/22/24 by the DCE. CNA #1 and CNA #2 were educated on proper lift and sling use and return demonstration was completed on 08/21/24 by the DCE. Checkoffs were completed by the DCE with all staff which were initiated on 08/21/24 and continue throughout all shifts until everyone completed. New Lift Transfer assessments were completed by the ADON on all current residents and care plans were updated on 08/22/24. Therapy referrals were made as needed by the ADON on 08/22/24 for anyone who required a lift and lift sling. Care Plans and Kardex updated as needed on 08/22/24 by the ADON. Team huddles with lift/transfer education completed 08/21/24 - 08/22/24 by the DCE. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	State Agency, Ombudsman, and Attorney General (AG's) office notified on 08/22/24 by Director of Nursing. In-Service on Lift/Transfer Program and Transfer Belts, Abuse/Neglect/Exploitation, and Elder Justice Program were completed by the DCE for all staff members with 100% compliance on 08/21/24 - 08/23/24. Topics included: Performance of lift usage, inspecting the sling prior to use, laundering slings and where to find them, and on the Kardex - only using care planned sling colors. In-Services initiated on 08/23/24 with Housekeeping and Laundry Manager on sling inspection and guidelines by the DCE. Hoyer Lift Policy and Procedures were reviewed with CNA #1 and CNA #2 and all other staff beginning on 08/21/24-08/22/24 by the DCE. Audits on all Lift Assessments were completed on 08/21/24 and are on-going by the ADON. Quality Assurance and Performance Improvement (QAPI) meeting was held on 08/30/24 and all required staff members were in attendance. Plan to continue the weekly audits and bring results to the monthly QAPI meetings for three (3) months.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide meals that included palatable food for five (5) of five (5) residents reviewed. Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6. Findings Include: Record review of the facility policy titled, Dining and Meal Service with effective date of January 1, 2017, revealed .Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. Resident #2 On 09/11/24 at 8:25 AM, an interview and observation revealed Resident #2 sitting up in his bed in his room with his breakfast tray on his overbed table. He revealed that he had been at that facility about 18 months and stated, You don't need to ask me about the food here because it's not good. He revealed that they served the same food over and over, the meat was half done sometimes and much of the food was hard, tough, and difficult to chew. An observation of Resident #2's breakfast tray revealed two pancakes, two slices of ham, and hot cereal. Resident #2 revealed that the pancakes were hard, and he could not cut them up to eat them this morning and stated, I don't eat most of the food. On 09/11/24 at 8:28 AM, an observation revealed Registered Nurse (RN) #1 enter Resident #2's room and confirmed that the pancakes were too hard to eat and she tried to cut them up for Resident #2 so he could eat them, but was unsuccessful. RN #1 was not able to cut the pancakes with a fork and stated, This is horrible. She revealed that they've had issues with the food for a while now and that they had been trying to get a different dietary company. RN #1 revealed that she knew of several complaints about food being too tough and hard to chew and stated, The bread is always hard. On 09/11/24 at 12:44 PM, an observation revealed Resident #2 sitting up in his wheelchair in his room with his lunch meal tray on his over bed table. He revealed that his chicken was overcooked, tough, and hard to chew. He revealed that he wasn't eating that stuff, it was too hard to cut up and it wasn't worth the trouble. Resident #3 On 09/11/24 at 8:40 AM, an observation and interview with Resident # 3 revealed that he had been there since August 2021. He revealed that the care was good, but the food was terrible. Resident #3 stated, If it's a blue moon out, the food might be good. He revealed that his pancakes were dry and so hard, he couldn't cut them to eat them. Resident #3 revealed that sometimes they had cinnamon rolls that were so hard that if you threw them at someone, you might put an eye out. He also revealed that some days the meat was tough and hard as shoe leather. Resident #3 revealed that he ordered door dash this morning and his breakfast was delivered to him and stated that that he just couldn't eat this food sometimes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Ripley	101 Cunningham Dr Ripley, MS 38663

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/11/24 at 9:30 AM, an interview with Administrator (ADM) revealed that they had issues with the food but he thought it was getting better since they had the new District Dietary Manager. ADM revealed that he had heard a few complaints about the food lately, but nothing major. He revealed that someone complained that the bread on their tray was hard, but he couldn't recall who had complained. ADM revealed that he hoped the new District Dietary Manager could make a difference. He revealed that there had been a lot of dietary staff turnover with the past district manager, and it seemed to be more consistent now and he was hoping things would improve. Resident #5 On 09/11/24 at 10:14 AM, an interview with Resident #5, Resident Council President, revealed that she had pancakes, ham, cereal and oatmeal this morning and it was just okay. She revealed that she didn't eat anything last night and she was hungry this morning. She revealed that the food really wasn't the best and if she didn't like it what was on her tray, she didn't eat it. On 09/11/24 at 12:50 PM, an interview with Resident #5, Resident Council President, revealed her sitting up in her recliner in her room and she said she had not received her lunch tray yet. She revealed that most of the time the food was so bad, she didn't eat it but when she was really hungry, she ate it anyway. Resident #5 revealed that everybody complained about the food. On 09/11/24 at 1:00 PM, an interview with Certified Occupational Therapy Assistant (COTA), revealed that they had a lot of residents complaining about the food. She revealed that the dietary department served frozen pancakes a lot and the edges were always hard and sometimes the whole pancake was too tough to eat. She revealed that they served French toasts sometimes for breakfast and they were always too hard for them to eat. COTA revealed that a lot of the residents had dentures, and some didn't have any teeth at all and stated, I don't see how they eat this stuff. She revealed that they had a lot of staff turnover in the dietary department and was hoping it would get better for the residents. On 09/11/24 at 1:19 PM, an observation revealed Resident #5, Resident Council President, sitting up in her recliner in her room with her lunch tray on her over bed table. There was a piece of fried chicken, mashed potatoes, spinach, and cornbread on her plate. Resident #5 stated, I don't know how this chicken is, I can't' get into it to see. She revealed that the chicken was too brown, overcooked and too hard. She revealed that she couldn't chew that outside part, it was too tough. Resident #5 stated, Looks like they cooked it too long. She revealed that they just can't get the food right. On 09/11/24 at 1:22 PM, an observation revealed COTA, enter Resident #5's room and looked at her lunch tray and confirmed that the chicken on her plate was overcooked, hard and observed resident trying to cut the skin off with her fork. Resident #5 stated, I can't chew that chicken, it's too tough. An observation also revealed COTA offer to assist Resident #5 to cut up her chicken, but resident declined, put her fork down and left the piece of chicken on her plate. On 09/11/24 at 1:25 PM, an observation revealed ADON enter Resident #5's room and stated, That chicken looks way over cooked and way too hard. ADON said that there was very little chicken meat there to eat because it was all dried out. ADON revealed if they got anything right at the facility, it should be their meals because that's all they had to look forward to. She offered to get Resident #5 something else to eat and she asked for a peanut butter and jelly sandwich. (continued on next page)

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	255102	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Ripley	101 Cunningham Dr Ripley, MS 38663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #4 On 09/11/24 at 1:09 PM an interview with Resident #4, revealed that he was pleased with the care he received at the facility, but they had problems with the food. He revealed that a lot of times the meat was not good, it was cooked too long, it was hard and tough to chew and that they served old, hard bread too. On 09/11/24 at 1:14 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed that she had worked in that facility for four and a half years. She revealed that the residents complained often about the food. LPN #1 revealed that food was sometimes cold when the residents received it and often the French toasts and pancakes were hard as a brick bat. On 09/11/24 at 2:00 PM, District Dietary Manager, walked to Resident #4's room, looked at her meal tray and confirmed that her piece of fried chicken was hard, overcooked and non-palatable and that she was not able to eat it. Resident #6 On 09/11/24 at 1:30 PM, an observation and interview with Certified Nursing Assistant (CNA) #1 in the hallway, revealed that she was going to the kitchen to get Resident #6 a ham and cheese sandwich he requested because his chicken was overcooked, hard and not fit to eat. CNA #1 confirmed that the chicken was tough, overcooked, and stated, It's hard as a brick. She also revealed that there was very little meat on the inside of the tough skin and what was there was dried throughout. She stated, I wouldn't give it to my dog. On 09/11/24 at 1:35 PM, an observation and interview with Resident #6 revealed a piece of fried chicken on his lunch tray and it was dark brown and hard to the touch. He revealed that the piece of fried chicken was tough and cooked too long and stated, I couldn't eat it. He revealed that CNA #1 was getting him a sandwich from the kitchen. He revealed that sometimes the food was good and sometimes it wasn't. Resident #6 revealed that his breakfast this morning was okay, that one of his pancakes was hard but he ate it anyway because he was hungry. Resident #6 revealed that he looked forward to his meals and wished that the food was better. On 09/11/24 at 1:55 PM, an interview with District Dietary Manager (DDM), revealed that providing palatable meals meant that the food should look appealing, should taste good, and the resident should be able to chew it. He revealed that they checked the chicken to make sure that it reached an internal temperature of 165 degrees. He revealed that they tried to make sure that the meat was not red or pink on the inside, so they often cooked it a little longer to make sure of it. He revealed that leaving food on the steam table too long could be making the food tough, but he wanted to keep it warm for the residents. DDM agreed that the food needed to be enjoyable because that's one thing the residents looked forward to. He revealed that he had been in that position about a month, and they were trying to fix the issues in all his facilities to make things better for the residents. He stated, It's all about keeping them happy and he revealed that he'd like to provide everything they wanted and needed. DDM revealed that he would work with his dietary staff on the food issues and try to come up with a plan to fix the problems. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/11/24 at 2:45 PM an interview with Social Worker (SW), revealed that she handled the facility grievances to make sure they were handled and resolved promptly. She revealed that there had been some issues with the food, they had new staff in the dietary department, and it was getting better. SW revealed that they had a lot of staff turnover in the dietary department and now had a new District Dietary Manager. She revealed that the food situation wasn't a one-person fix, it was going to take the team to work together to resolve the issues. SW revealed that there had been complaints about the toast being too hard to eat, the meat being tough, and the food often cold by the time the residents received it. SW revealed that this was the residents' home, and they deserved better. She revealed that she had talked to dietary staff, and they needed to do better with preparing the meals. She also revealed that they were working on getting a plan in place to make the food situation better. Record review of the facility Weekly Menu revealed that the breakfast meal on Wednesday, 09/11/24, was Buttermilk Pancakes, Hot Cereal, Breakfast Ham, Milk, Coffee or Hot Tea, and Orange Juice. On Wednesday, 09/11/24, the lunch meal was Fried Chicken, Mashed Potatoes, Seasoned Spinach, Cornbread, and Mandarin Oranges. Record review of Resident #2's Admission Record revealed an admitted [DATE] with diagnoses that included Need for Assistance with Personal Care, Dysphagia, and Type 2 Diabetes Mellitus. Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/22/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that he was cognitively intact. Record review of Resident #3's Admission Record revealed an admitted [DATE] and had diagnoses that included End Stage Renal Disease, Need for Assistance with Personal Care, and Type 2 Diabetes Mellitus. Record review of Resident #3's MDS with ARD of 08/23/24 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Record review of Resident #4's Admission Record revealed an admitted [DATE] and had diagnoses that included Chronic Obstructive Pulmonary Disease and Dysphagia. Record review of Resident #4's MDS with ARD of 07/11/24 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Record review of Resident #5's Admission Record revealed an admitted [DATE] and had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care. Record review of Resident #5's MDS with ARD of 07/02/24 under Section C revealed a BIMS score of 15 which indicated that she was cognitively intact. Record review of Resident #6's Admission Record revealed an admitted [DATE] and had diagnoses that included Dysphagia and Need for Assistance with Personal Care. Record review of Resident #6's MDS with ARD of 07/09/24 under Section C revealed a BIMS score of 14 which indicated that he was cognitively intact.