STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Southaven	1730 Dorchester Dr Southaven, MS 38671

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, staff interview, record review and facility policy review, the facility failed to provide a resident with sheets and a blanket while their bedroom window was open and 38 degrees outside for one (1) of 11 residents on sample. Resident # 2 Findings include: Review of the facility policy titled, Resident Rights Summary with a revision date of 5/1/12 revealed #1. Exercise of Rights: The resident has the right to exercise his/her rights as a resident of the facility and as a citizen of the United States . An observation on 3/18/24 at 6:25 AM, revealed Resident #2 lying in bed with no sheets or a bedspread observed, resident was lying on the bare mattress. The resident's knees were pulled up to his chest and he was covered in an approximate 30 inch by 30-inch velour throw and had one folded in a square under his buttocks. This observation revealed the resident's curtains were blowing in and out and when the curtains were pulled open it revealed the window was cracked open and the current temperature outside was 38 degrees. An interview on 3/18/24 at 6:30 AM, with Licensed Practical Nurse (LPN) #3 confirmed she was Resident #2's nurse and was not sure why the resident did not have sheets or proper blankets on him or why the window was open. She stated that the window did not need to be opened and he needed some linens and a blanket on his bed because it was cold outside. An interview and observation on 3/18/24 at 6:40 AM, with Certified Nurse Assistant (CNA) #3 confirmed she was Resident #2's CNA and she confirmed the resident did not have sheets or a blanket because they did not have any clean linens in the building and that it happens a lot. She stated she is not sure why the window was open, but she realized it was cold in there and turned the air off in his room a little bit ago. An interview and observation on 3/18/24 at 7:00 AM, with the Administrator confirmed that Resident #2 should have sheets and a blanket to cover him, and his window should not have been opened with it that cold outside. The Administrator confirmed with a laundry staff member that there were no clean blankets or linens at this time. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/20/24 at 10:00 AM, with the Director of Nurses (DON) confirmed that Resident #2 should have had sheets on his bed and a blanket big enough to cover him, because that is his right. She stated she is not sure why the window was open, but the staff should have seen that and closed it. She stated that Resident #2 not having sheets on his bed and not having a blanket to fully cover him is a basic human right and he should have had better. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Hypokalemia. Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/7/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident is moderately cognitively impaired.

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	255109	A. Building B. Wing	03/20/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observations, staff and resident interview, record review and facility policy review, the facility failed to provide a safe, clean, homelike environment as evidenced by damaged floors on the East Wing, trash build up, unclean floors and no clean linens for two (2) of three (3) wings. Findings Include: Review of the facility policy titled, 5-Step Daily Room Cleaning with no revision date revealed, Purpose . proper cleaning method to sanitize a patient room or any area in a healthcare facility .1. Empty Trash, 2. Horizontal Surfaces-disinfect, 3. Spot Clean Walls, 4. Dust Mop, 5. Damp Mop; The most important area of a patient's room to disinfect is the floor .When damp mopping floors pay close attention to any possible build up . Review of the facility policy titled, Structuring the Laundry System with a revision date of 10/25/18 revealed, . Stage 1: Establishing Linen PARS .A linen par is the amount of linen needed to satisfy the daily needs of each and every resident .The rule of thumb is that linen inventory should be a minimum of 3 times your par (the amount of linen needed to satisfy the daily needs of each and every resident), 8 times par for wash cloths . Review of the facility policy titled, Work Orders and Paging with a revision date of 9/1/14 revealed, Purpose . To establish a productive procedure for communicating and coordinating the needs of residents and employees from the Maintenance Department . An observation on 3/18/24 at 6:05 AM, of the East wing hall leading to the nurse's station from the front entrance revealed three areas of buckled, unsecured vinyl flooring that was torn and raised up from the concrete floor. There were two indentions in the floor that was approximately 3 inches wide and 1 inch deep, multiple uneven areas and multiple peeling laminate that was sticking up. One area was approximately 5 feet long by 7 feet wide and was closest to the ice machine on that hall, and the other two areas closest to the nurse's station were approximately 20 feet long by 7 feet wide and one was 10 feet long by 7 feet wide. This hall is a high traffic area and is the path traveled for residents, staff, and visitors from their rooms on the East halls to the dining room. This observation revealed there were no cones or precaution signs to alert staff, residents or visitors of the damaged, uneven floor. An observation on 03/18/24 at 6:20 AM, of the [NAME] wing hall revealed the floors were dirty and had discarded pieces of paper, dried liquid stains and food crumbs throughout the hall. An observation on 3/18/24 at 6:28 AM, revealed Resident #2 lying in bed with no sheets or a full blanket. The resident's knees were pulled up to his chest and he was covered in an approximate 30 inch by 30-inch velour throw and had one folded under his buttocks. This observation revealed the resident's curtains were blowing in and out and when the curtains were pulled open it revealed the window was cracked open and the current temperature outside was 38 degrees. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 3/18/24 at 6:30 AM, with Licensed Practical Nurse (LPN) #3 confirmed she was Resident #2's nurse and was not sure why the resident did not have sheets or proper blankets on him or why the window was open, but it did not need to be, and he needed some linens on his mattress. She revealed that the floor on the East Hall had been messed up for a while now, but she is not sure what they have done to fix it and stated she thinks they had a water leak. An interview and observation on 3/18/24 at 6:42 AM, with Certified Nurse Assistant (CNA) #3 confirmed she is Resident #2's CNA and she confirmed the resident did not have sheets or a blanket because they did not have any linen and that happens a lot lately. She confirmed the resident deserves to have a full blanket and sheets, but she is doing the best she can because that was all she could find to put on him. An observation/interview, on 03/18/24 at 6:45 AM, revealed that the [NAME] Wing shower room door was propped open with a maintenance cart. Certified Nurse Assistant (CNA) #2 revealed that shower room has been broken for about two (2) months because there was some problem with the water, but they are having to change the shower head. CNA #2 confirmed that the residents have been receiving bed baths. CNA #2 stated, We don't have enough linen to take care of the residents because we only have one washer working. Observation on 03/18/24 at 6:48 AM, of the linen closet on the [NAME] Wing revealed one fitted sheet and one flat sheet. There were no towels, wash cloths or blankets. An observation on 03/18/24 at 06:50 AM, of room [NAME] 16 B revealed there was an area approximately three (3) foot by two (2) foot of dried brown sticky substance running underneath the resident's bed. An observation/interview on 03/18/24 at 6:55 AM, of resident room [NAME] 22 A revealed there were small brown and white crumbs of food scattered on the floor from the top of the resident's bed to the foot of the bed and a brown sticky substance splattered on the floor in an area approximately two (2) feet by 2 feet on the right side of the bed . An observation with CNA #3 on 03/18/24 at 7:00 AM, of the linen closet on the East Wing confirmed there were no linens of any type, the closet was empty. She stated she went to the laundry room when she came on duty at 11 PM and there were no clean linens in the laundry room at that time. Laundry staff #1 walked past as we were viewing the empty linen closet and confirmed there was no clean linens, because they were down to one washer and stated she has some sheets washing now but that it will be awhile. An interview and observation on 3/18/24 at 7:00 AM, with the Administrator revealed when she attempted to enter the laundry room from the dirty side that there were so many bags of dirty laundry, she could not open the door all of the way. She stated the reason they were behind on laundry was because they only work one shift and do not work at night. She stated, I'll be honest I was not aware that we were down to one washing machine. The Administrator confirmed that Resident #2 needed sheets and a blanket covering him and asked the laundry staff to take one to him immediately. Laundry Staff #1 informed her she did not have any clean blankets at this time. The Administrator ask Laundry Staff #1 to get some in the washer and she stated as soon as this load is finished I will. The Administrator then stated she was aware that the washing machine had broken down and that they were trying to get it fixed but did not know any details. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 3/18/24 at 7:30 AM, with LPN #4 revealed there were three yellow poles on the East Hall with the damaged floors covering the approximate 3 inch wide by 1-inch-deep holes. LPN #4 stated that they put yellow poles up in three places for an area that is approximately 10 feet long and 7 feet wide to alert residents to avoid the floor hazards in that area. She confirmed the facility had multiple water leaks in the floors and the floors had to be repaired multiple times. She revealed that the three yellow poles did not cover all of the areas of the floor that was damaged, and it could be a hazard for residents trying to walk over the damaged floor areas. An observation and interview on 3/18/24 at 7:40 AM, with the Administrator confirmed the floor is damaged on the East Hall due to more than one water leak. She stated that they were supposed to come fix it two weeks ago but the work crew didn't show up. She confirmed that the floor could be hazardous for residents due to its condition. An interview and review of invoices regarding water leak repairs and replacement flooring with the Administrator on 3/18/24 at 8:30 AM, revealed there had been two water leaks in the concrete slab floor on the East Hall that had to be repaired with the first one being 5/27/23 and the second one occurred 11/7/23-11/14/23. Review of the invoice for replacement flooring revealed it was ordered on 3/13/24 and is scheduled to be replaced on 3/20/24. A confirmation interview with the Administrator confirmed that she had said they were supposed to have been at the facility two weeks ago to replace the floors, but that the floors were not ordered until last week. She confirmed that it had been almost nine (9) months since the first water leak that damaged the floors. An interview on 3/18/24 at 9:00 AM, with CNA #4 revealed that she has had complaints from family and residents about the cleanliness of the facility. She revealed that housekeeping does not work at night, and she has noticed that some of the floors in the rooms are not clean; they could do better. An observation on 03/18/24 at 10:00 AM, revealed Housekeeper #4 entered resident room [NAME] 16, The housekeeper was noted coming out of the room and going back into the room with a mop. An interview on 03/18/24 at 10:12 AM, with Registered Nurse (RN) #1 confirmed that the floor in room [NAME] 16 still had a dried brown substance on the floor and needed to be cleaned. RN #1 stated, The floor needs to be cleaned. An observation/interview on 03/18/24 at 10:15 AM, of Housekeeper #4 coming out of resident room [NAME] 16, she confirmed that she was finished cleaning the resident's room. An observation of the residents' floor revealed the dried splattered brown substance was still on the floor and underneath the resident's bed. RN #1 was standing outside of the residents' door. RN #1 entered the room and confirmed that the feeding was still on the floor and underneath the bed and that it did not provide a clean environment for the resident. RN#1 confirmed that the housekeeper had just exited the resident's room but did not clean the brown substance off the floor and that it did not appear that she had mopped the resident's floor at all. An interview on 03/18/24 at 10:20 AM, with Housekeeper #4 confirmed that she did not get the dried brown substance off the floor. Housekeeper #4 stated It's not our job to get the milk up. This is my first day back anyway from maternity leave, so that's not on me. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 03/18/24 at 10:30 AM, of Resident #6 lying in bed with a urinal underneath a chair that sat against the wall in the center of the room. Resident #6 confirmed that the urinal underneath the chair belonged to the resident who was in the room before him and was not his. An interview and observation on 03/18/24 at 12:47 PM, with LPN #4 confirmed that the urinal underneath the chair in Resident #6's room belonged to the resident that was in the room previously and had not been removed. She revealed that Resident #6 was admitted to that room on 3/8/24 and it appeared that the room had not been cleaned. An interview on 3/19/24 at 9:00 AM, with Resident #3 revealed that he can self-propel his wheelchair and the floor on his hall (East) has a place that is hard for him to roll his wheelchair over. They sometimes have to push me over that area. He stated the floor is rough in that area and it's been like that for a long time. An observation and interview on 3/19/24 at 10:00 AM, with Maintenance Staff #2 confirmed the floors on the East Hall was unlevel because of several water leaks and that they had to tear up the floor back last year. He stated that after the last water leak, they Had us fix it with self-leveling concrete and lay new vinyl flooring. He revealed that maintenance laid the self-leveling concrete but it did not work and the floors were not level, with dips and holes in the floor and also peeling and pulled up vinyl planks for an area approximately 10 feet long by 7 feet wide near the nurse station, an area approximately 20 feet long and 7 feet wide toward the middle of the East Hall in front of rooms E 8-E 12 and an area 5 feet long and 7 feet wide at the end of the East Hall in front of the ice machine. He admitted that the floor was unlevel and could be dangerous to residents and visitors. He stated he was made aware on Friday morning 3/15/24 that one of the washers was out, and he found that the water hose had busted. He revealed that he replaced the water hose but forgot to turn the hot water back on. He stated that he repaired that first thing Friday morning and left the facility around 4:30 PM with no one making him aware that the washer still wasn't working before he left. He admitted that he never told the Administrator anything about that but should have. Record review of the invoices for water leak repairs revealed the East Hall had two water leaks. The review of the invoice dated 6/28/23 from (Proper name) Companies, Inc revealed multiple leaks and repairs were made over the days from 5/27/23 to 6/1/23. The notation dated 6/1/23 revealed that the repair company left the slab a little low for whoever replaced the floor to use leveling compound to make sure the flooring grade matched the existing; cleaned up the site and left. Review of the invoice dated 11/27/23 revealed (Proper Name) Companies Inc repaired a floor leak between 11/7/23 and 11/14/23. Record review of the invoice dated 3/13/24 from (Proper Name of flooring company) revealed that 470.86 square feet of flooring had been ordered. An observation and interview with CNA #5, DON and Administrator on 3/19/24 at 11:00 AM, revealed multiple bags of foul-smelling garbage piled up to the counter height and to the door in the biohazard room on the East Wing. An interview with CNA #5 confirmed she could barely open the door and she cannot get to the replacement battery for her total lift that is charging in that room. An interview and observation with the DON and Administrator confirmed that was a lot of bagged garbage that appeared to be resident's dirty briefs and staff should have already taken that out. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 3/19/24 at 11:15 AM, with the Environmental Manager revealed he took over this facility a short time ago and it still needs work. He stated that he was not aware that the washer broke on Friday, and he honestly does not know for sure if it is housekeeping's responsibility to take the garbage out every morning from the biohazard room, but he will get to the bottom of it. He revealed that there should have been clean linen available for the residents. An observation and interview on 3/19/24 at 11:30 AM, revealed Housekeep Staff #5 rolling a large barrel of foul-smelling garbage down the hall. On interview she confirmed it came from the biohazard room on the East Hall and it was her or the floor techs responsibility to take it out every morning. She stated I've been talking to the Administrator and the one before her about taking this responsibility off of me. She stated that the current Administrator told her they have to baby the CNA's. She stated she was supposed to have taken it out this morning but got busy doing paperwork. She stated that this is 3 PM-11 PM AND 11 PM-7 AM' s' garbage because they don't want to take it out there in the dark. An interview on 3/19/24 at 3:15 PM, with Laundry Staff #3, assistant supervisor, stated she walked up to the Administrator where she was sitting at the conference table for the stand-up meeting on Friday and told her the washer was out and they had staffing issues. She stated that Maintenance came and looked at the washer on Friday but did not fix anything and told us he would have to call someone to come look at it. An interview on 3/20/24 at 10:00 AM, with the Director of Nurses (DON) stated that Resident #2 not having sheets on his bed and not having a blanket to fully cover him is a basic human right and he should have had better, but I realize they were doing the best they could do since they did not have any clean linen. She confirmed that the garbage in the biohazard room that was resident's dirty briefs and such should have been taken out first thing yesterday morning and the staff that were responsible for that knew to do it. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/7/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident is moderately cognitively impaired. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #3's MDS with and ARD of 2/3/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact. Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #6's MDS with an ARD of 1/24/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for 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** 39807 Based on observation, resident and staff interview, record review and facility policy review the facility failed to implement a comprehensive care plan for a resident requiring assistance with Activities of Daily Living (ADLs) for three (3) of 11 residents sampled. Resident #1, Resident #3, and Resident #6. Findings include. A review of the facility policy titled MDS and Care Plans, Effective August 2019 revealed, Policy: Care plans and MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines. Resident #6 A record review of Resident #6's care plan revealed he has an ADL self-care performance deficit related to cognition with interventions which included assist with facial hair daily and as needed, he is dependent on one person's assistance for bathing, and requires extensive assistance of one staff with personal hygiene. An observation and interview of Resident #6 with the Treatment Nurse present on 03/18/24 at 10:30 AM, revealed the resident lying in bed awake and alert times. The resident was disheveled wearing only a shirt and a brief. The resident's hair was oily, and he had facial hair covering his cheeks and chin that was approximately one-half inch long. The resident stated, They haven't shaved me in a long time, and I want them to shave the hair off of my face. The resident could not remember the last day he received a shave. The resident confirmed that he had not had a shower in about two (2) weeks and that he would like to go to the shower. Resident #6 stated, They have been washing me up in bed'. The Treatment Nurse confirmed that the resident's hair was oily and that he needed a shave and a shower. An interview on 03/20/24 at 10:05 AM with the Minimum Data Set (MDS) Nurse confirmed that Resident #6 has a care plan for assistance with ADL care. The MDS Nurse confirmed that the resident requires extensive assistance of one with bathing on Tuesday, Thursday, and Saturday. The MDS Nurse stated I don't see where he has had but one bath since the beginning of March 2024 and if they have not given him a bath, they are not following the care plan. The MDS nurse confirmed that the purpose of the care plan is to guide the residents care in a safe manner. The MDS nurse confirmed that not following the care plan could result in the resident not getting the care he is supposed to get. An interview on 03/20/24 at 10:30 AM with the Director of Nursing (DON) confirmed that the purpose of the care plan is to guide the resident's care. The DON confirmed the resident not receiving his bath and a shave means the staff was not following the care plan, which could result in the resident not getting the care that he is supposed to get. A record review of Resident #6's MDS section GG revealed that the resident requires substantial/maximal assistance with showering, bathing, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Admission Record for Resident #6 revealed that he was admitted to the facility on [DATE] with medical diagnoses that included muscle weakness, unsteadiness on feet and need for assistance with personal care. 44804 Resident #1 Record review of Resident #1's Care Plans revealed the resident has an ADL and physical functioning deficit related to weakness and debility and contractures to bilateral fingers. Resident #1 requires the need for extensive assistance with toileting. An interview on 3/18/24 at 9:40 AM with Resident #1 revealed she has to wait for a female Certified Nursing Aide (CNA) or nurse to come provide her care, because they have other residents assigned to them. She stated she has complained about not wanting to have a male CNA and there is always a male assigned to her, so she has to wait for the female CNA to provide incontinent care. She stated she had talked with both the head nurse and the administrator. She stated she has waited 2 hours several times and one time she waited eight (8) hours while she was wet, just to get a female to change her and clean her up. Record review of the Admission Record for Resident #1 revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Other Specified Arthritis, multiple sites. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/23 revealed in Section GG that the resident needed assistance with Activities of Daily Living (ADL). Resident #3 Record review of Resident #3's care plans revealed the resident has an ADL self-care deficit related to chronic debilitation, generalized weakness and history of CVA with right side weakness. Interventions include extensive assistance of 2 staff for toileting. An interview on 3/19/24 at 9:00 AM with Resident #3 revealed he gets mainly bed baths. He stated that it has been so long since he has had a shower that he can't remember when it was. He stated he preferred to get a shower because it's always warm. He revealed he has to have help going to the bathroom, but they are slow to get to him sometimes and they never ask to take him to the bathroom during the day when he is up in his wheelchair. He laughed and said oh no they are not going to ask that would mean they would have to take me. An interview on 3/20/24 at 10:00 AM with the Director of Nurses (DON) confirmed that residents not getting their incontinent care timely and getting bed baths instead of showers has been a problem. She confirmed that residents do get mainly bed baths because some of the aides think it is easier. She stated that not all of her nursing staff are meeting her expectations of basic human needs and care and therefore not always following residents care plans. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's MDS with and ARD of 2/3/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Southaven	1730 Dorchester Dr Southaven, MS 38671

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39807 Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide assistance with Activities of Daily Living (ADL) for residents that required assistance for three (3) of seven (7) sampled residents. Resident # 6, #1, and #3. Cross Reference F725 Findings Include. A review of the facility policy titled ADL's Effective August 2021, revealed, Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences. Resident #6 On 03/18/24 at 10:30 AM, observation/interview of Resident #6 with the Treatment Nurse present revealed the resident lying in bed and appeared disheveled wearing only a shirt and a brief. The resident's hair was oily, and he had facial hair that was covering his cheeks and chin and was approximately one-half inch long. The resident stated, They haven't shaved me in a long time, and I want them to shave the hair off of my face. The resident could not remember the last day he received a shave. The resident confirmed that he had not had a shower in about two (2) weeks and that he would like to go to the shower. Resident #6 stated, They have been washing me up in bed'. The Treatment Nurse confirmed that the resident's hair was oily, had a large amount of facial hair that needed to be shaved and needed to have a shower. On 03/18/24 at 12:47 PM, interview with Licensed Practical Nurse (LPN) #3 confirmed that Resident #6 had not been shaved recently and was unsure of the date of the last shave because she could not find the bath sheet. LPN# 3 confirmed that the resident is supposed to receive a bath on Tuesday, Thursday, and Saturday. LPN #3 confirmed that the residents having a bath and being clean helps prevent skin breakdown. On 03/18/24 at 1:15 PM, an interview with LPN #2 confirmed that there was only one bath sheet on 03/12/24 for Resident #6. LPN #2 confirmed that the resident is supposed to receive a bath on Tuesday, Thursday, and Saturday and that he should be shaved when he receives a bath. LPN #2 confirmed that the purpose of the bath is to keep the resident's skin clean to prevent breakdown and infections. A review of the facility Admission Record for Resident #6 revealed that he was admitted to the facility on [DATE] with medical diagnoses that included Muscle Weakness, Unsteadiness on feet and Need for assistance with personal care. 44804 Resident #1 (continued on next page)

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	255109	A. Building B. Wing	03/20/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/24 at 9:40 AM, an interview with Resident #1 revealed she has to wait for a female Certified Nursing Assistant (CNA) or nurse to come provide her care, because they have other residents assigned to them. She stated she has complained about not wanting to have a male CNA and there is always a male assigned to her, so she has to wait for the female CNA to provide incontinent care. She stated she had talked with both the head nurse and the Administrator. She stated she has waited 2 hours several times and one time she waited eight (8) hours while she was wet, in order to get a female to change her and clean her up. On 3/19/24 at 3:05 PM, interview with the Ombudsman confirmed that Resident #1 complained that she has to wait a long time for the female aids to provide incontinent care because they have other residents, and she has made the Administrator aware. She stated the resident informed her that staff told her, You are just going to have to deal with it. Review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Other Specified Arthritis, other sites. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact and in Section GG that the resident needed assistance with ADLs. Resident #3 On 3/19/24 at 9:00 AM, an interview with Resident #3 revealed he gets mainly bed baths. He stated that it has been so long since he has had a shower that he can't remember when it was. He stated he preferred to get a shower because it's always warm. He revealed he has to have help going to the bathroom, but they are slow to get to him sometimes and they never ask to take him to the bathroom during the day when he is up in his wheelchair. He laughed and said, Oh no they are not going to ask that would mean they would have to take me. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #3's MDS with and ARD of 2/3/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact and in Section GG indicated the resident needed supervision and/or touching assistance with toileting. On 3/19/24 at 3:30 PM, an interview with LPN #5 confirmed that the residents do not get showers like they should, and she has told the Administrator about that. She said my residents have had showers for the past two days, but it is because you all have been here. On 3/20/24 at 10:00 AM, in an interview with the Director of Nurses (DON) confirmed that residents not getting their incontinent care timely and getting bed baths instead of showers has been a problem. She confirmed that residents do get mainly bed baths because some of the aides think it is easier. She revealed that is something she has been working on since she got here. She confirmed that not all of her nursing staff are meeting her expectations of basic human needs and care. She revealed she feels like they have plenty of staff, they just have some lazy staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	03/20/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39807 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide sufficient staff as evidenced by staff not providing assistance with bathing, grooming and personal hygiene for three (3) of seven (7) sampled residents residing in the facility. Resident #1, Resident #3,and Resident #6. Cross Reference F677 Findings include: A review of the facility policy titled ADL's Effective August 2021, revealed, Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences . An interview on 03/18/24 at 6:30 AM, with Certified Nurse Aide (CNA) #1 confirmed that the nurse aides on the night shift have approximately 20 residents each to care for and that it is too many to take care of them properly. CNA # 1 stated that they used to have four (4) nurse aides on the night shift for one (1) wing, but they cut the number of nurse aides back to three (3). CNA #1 stated. They said they had to cut us back because of the budget or something. An interview on 03/18/24 at 6:45 AM, with CNA #2 confirmed that having only 3 nurse aides on the night shift that they have a hard time getting everyone's care done timely. Resident #1 During an interview on 3/18/24 at 9:40 AM, with Resident #1 revealed she has to wait for a female CNA or nurse to come provide her care, because they have other residents assigned to them. She stated she has complained about not wanting to have a male CNA and there is always a male assigned to her, so she has to wait for the female CNA to provide incontinent care. She stated she had talked with both the head nurse and the Administrator, but she has waited two (2) hours several times and one time she waited eight (8) hours while she was wet just to have a female CNA change her. During an interview on 3/19/24 at 3:05 PM, with the Ombudsman confirmed that Resident #1 complained that she has to wait a long time for the female aids to provide incontinent care because they have other residents, and she has made the Administrator aware. She stated the resident informed her that staff told her, You are just going to have to deal with it. Review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact and in Section GG that the resident needed assistance with Activities of Daily Living (ADL). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 During an observation/interview on 03/18/24 at 10:30 AM, of Resident #6 and the Treatment Nurse present revealed the resident lying in bed awake and appearing disheveled wearing only a shirt and a brief. The resident's hair was oily, and he had facial hair covering his cheeks and chin that was approximately one-half inch long. The resident stated, They haven't shaved me in a long time, and I want them to shave the hair off of my face. The resident could not remember the last day he received a shave. The resident confirmed that he had not had a shower in about two (2) weeks and that he would like to go to the shower. Resident #6 stated, They have been washing me up in bed'. During an interview on 03/18/24 at 1:15 PM, with Licensed Practical Nurse (LPN) #2 confirmed that there was only one bath sheet indicating the days he received a bath on 03/12/24 for Resident #6. LPN #2 confirmed that the resident is supposed to receive a bath on Tuesday, Thursday, and Saturday and that he should be shaved when he received a bath. Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #6's MDS with an ARD of 1/24/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact. Resident #3 During an interview on 3/19/24 at 9:00 AM, with Resident #3 revealed he gets mainly bed baths. He stated that it has been so long since he has had a shower that he can't remember when it was. He stated he preferred to get a shower because it's always warm. He revealed he has to have help going to the bathroom, but they are slow to get to him and they never ask to take him to the bathroom during the day when he is up in his wheelchair. He laughed and said Oh no they are not going to ask, that would mean they would have to take me. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #3's MDS with an ARD of 2/3/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact and in Section GG indicated the resident needed supervision and/or touching assistance with toileting. An interview on 3/19/24 at 3:30 PM, with Licensed Practical Nurse (LPN) #5 confirmed that staffing is an issue. She stated she has 30 residents with 15 blood sugars and vital signs and 15-20 meds per resident normally. She stated it is too overwhelming and I've been a nurse in Long Term Care (LTC) for [AGE] years and this is the worst place that I have seen. She revealed she has voiced these concerns to the Administrator but did not get a response. She stated that the LPN on 11-7 shift has 60 residents she is responsible for and that it is just too much. She confirmed that the residents do not get showers like they should, and she has told the Administrator about that. She said my residents have had showers for the past two days, but it is because you all have been here. (continued on next page)

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	255109	A. Building B. Wing	03/20/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24 at 10:00 AM, with the Director of Nurses (DON) confirmed that not all of her nursing staff are meeting her expectations of basic human needs and care. She revealed she has had to start with the basic bottom line of incontinent care, nutrition, and wounds since she has been here. She stated that not all staff are attentive as they need to be with their care. She confirmed that residents not getting their incontinent care timely and getting bed baths instead of showers has been a problem and is reflected in the amount of moisture associated skin disorders we have had in the past. She confirmed that residents do get mainly bed baths because some of the aides think it is easier. She revealed that is something she has been working on since she got here. She revealed she feels like they have plenty of staff, they just have some lazy staff. An interview on 03/20/24 at 12:51 PM, with the Workforce Manger confirmed that she was aware that she ran low on staffing scheduling on 03/16/24 and 03/17/24. The Workforce Manager stated, I only received training on completing the schedule for one (1) day before I started doing it. The Workforce Manager confirmed that there were not enough staff providing resident care if she had someone requiring one-on-one or had an orientee working. She stated I just copy my monthly schedule onto the staffing grid, and I never make changes to my schedule to reflect if someone calls in or not, so I don't ever know what the numbers equal out to. I thought the Administrator was looking at that, because I'm not. An interview on 03/20/24 at 1:00 PM, with the Administrator revealed that she was unaware that the Workforce Manager had not been trained in staffing and that it could cause staffing concerns and the staff scheduled to be wrong. 44804

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, staff and resident interview and facility policy review, the facility failed to ensure that call lights were functioning in all resident rooms as evidenced by Resident #3 and Resident #6's call lights not functioning for two (2) of seven (7) residents sampled. Findings Include: Record review of the facility policy titled, Nurse Call System with a revision date of 9/1/14 revealed, Policy . To maintain center nurse call systems in an ideal mechanical condition to ensure optimum performance when residents request assistance from staff . An observation on 3/18/24 at 6:15 AM, of Resident #3's room revealed the call light outside the room door was on, but no noise was alerting staff. An interview on 3/18/24 at 6:16 AM with Licensed Practical Nurse (LPN) #3 confirmed that Resident #3's call light is not working and stays on all of the time, so they have bells. An observation and interview on 3/18/24 at 6:17 AM, with Resident #3 revealed there were no call light cords in the resident's room, no bell was noted and he has no idea if he has a call light and has never had a bell. He stated he has seen a call light cord before, but it's been a while. He picked his cell phone up and stated he used this if he had to. An interview on 3/18/24 at 6:18 AM with Licensed Practical Nurse (LPN) #3 confirmed that she needed to put a work order in for Resident #3's call light and stated that she thought they had bells to ring, but confirmed that they didn't. An interview and observation on 3/18/24 at 9:13 AM, with LPN #4 revealed that as far as she knew, all the call lights worked, and no one has had a bell in a long time. On this observation it was revealed that Resident #3 had call light cords and when they were pulled the light came on but did not make a noise. She stated a work order needs to be put in for this, I had no idea. She stated she was going to notify maintenance. An observation and interview on 03/18/24 at 10:30 AM, with Resident #6 stated that the staff comes when he calls for them. The resident pressed his call light, and the call light did not work. The treatment nurse LPN #1 was present in the residents' room and confirmed that the call light was not working. An interview and observation on 3/19/24 at 11:00 AM with the Administrator and the Director of Nurses (DON) of Resident #3's room confirmed that the residents' call light would come on when it was pushed but there was no sound at the nurse's station to alert staff that the resident needed help. They confirmed that a work order should have been put in by the staff that were aware it was broken. The Administrator revealed if staff are aware that there are problems with a call light then a work order needed to be put in and they need to let me know. She stated that she would investigate to find out why Resident #3's room did not have call light cords on observation at 3/18/24 at 6:17 AM. She revealed that the call light would come on and stay on when the cord is pulled out of the wall. (continued on next page)

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	255109	A. Building B. Wing	03/20/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 3/19/24 at 10:00 AM with Maintenance Staff #2 confirmed that the call light in Resident #3's room came on with no noise and needed to be fixed, but he had not been made aware that it was broken. An interview on 3/20/24 at 10:00 AM with the Director of Nurses (DON) confirmed that residents not having functioning call lights is an issue that could lead to a problem for the resident if they are not able to call for help. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/24 revealed in Section C a BIMS score of 13, which indicated the resident is cognitively intact. Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #6's MDS with and ARD of 1/24/24 revealed in Section C a BIMS score of 13, which indicated the resident is cognitively intact.