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	03/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47158 Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from neglect when the facility staff neglected to refer to the kiosk Kardex to ensure staff transferred the resident with the required number of staff members and failed to use the proper assistive device for one (1) of three (3) residents reviewed. Resident #1 Findings Include: Record review of the facility policy titled, Lift 4 Care-Safe 4 All revealed Purpose: To provide team members guidance with assisting patients and residents to safely reposition or transfer . 7. In order to maintain patients' 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. Record review of the facility Kardex Guidelines revealed Purpose: to ensure optimal communication and connection between our caregivers and residents resulting in enhanced quality of care and life . The Kardex will be reviewed daily in clinical startups and updated with any changes in a resident condition. Team members providing care will view the Kardex through the POC (Plan of Care) portal. A record review of the facility investigation revealed that on 3/14/25, while Resident #1 was being transferred to bed by Certified Nursing Assistant (CNA) #1, the resident stated, ow, and CNA #1 eased the resident to the floor. CNA #1 immediately notified the nurse. Upon evaluation, no injury or complaint of pain was noted. After assessing the resident, the Registered Nurse (RN) assisted her back to bed, identifying no apparent injury, bruising, or swelling. However, within 48 hours, swelling was observed above the right knee. An intervention was provided for comfort, and the physician was notified of the change in conditions. An X-ray revealed a fracture above the previous joint replacement device. The Nurse Practitioner (NP) and the Responsible Party were notified, and Resident #1 was transferred to the local emergency room for further evaluation and treatment. A record review of the Computed Tomography (CT) scan of Resident #1's right knee from the local hospital, dated 3/20/25, revealed an acute comminuted periprosthetic fracture of the distal femoral metaphysis. A record review of the Lift Transfer Evaluation, dated 4/7/24, revealed that Resident #1 required a total lift with a medium yellow sling for transfers. (continued on next page)

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
	255109	A. Building B. Wing	03/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of a printout of the Kiosk Kardex for Resident #1 revealed the following: Safety .Two members will assist with transfers with each episode .Lift 4 Care: type of lift, sling size, etc. total lift with medium yellow sling. During an interview with the Administrator on 3/26/25 at 9:15 AM, she verified that the facility investigation confirmed that on the evening of 3/14/25, CNA #1 transferred Resident #1 to bed using a stand-pivot transfer method instead of a lift and had to lower the resident to the ground. During the transfer, the resident said, ow, but upon assessment by the RN, no injury was noted. She stated that within 48 hours, Resident #1 was moaning during care. Upon assessment by the nurse, the resident's right knee was swollen and tender to touch. The resident was assessed by the NP, who noted swelling but no other signs of trauma. A right knee X-ray was ordered on 3/19/25, and results received on 3/20/25 revealed a fracture of the femoral shaft. The NP was notified, and orders were given to transfer the resident to the hospital. A record review of the Progress Notes from 3/14/25 through 3/20/25 confirmed that on 3/16/25, the resident was moaning during care, prompting the nurse to be notified. The resident was observed to have swelling in the right knee with tenderness to touch. The leg was elevated for comfort, and the NP was notified. On 3/17/25, the resident was assessed by the NP, who noted swelling in the right knee without redness, tenderness, warmth, or pain. The resident was diagnosed with right knee effusion, and the current treatment with diuretics was continued. On 3/19/25, the NP saw the resident again, observing no change in the knee's condition. An X-ray of the right knee was ordered. On 3/20/25, the NP noted that the resident continued to have knee swelling without pain. The X-ray results showed a femur fracture, and the NP ordered the resident's transfer to the emergency room for further evaluation and treatment. During a telephone interview with CNA #1 on 3/26/25 at 11:32 AM, she confirmed that on the evening of 3/14/25, she transferred Resident #1 from the chair to the bed by standing the resident up and pivoting her to bed. She explained that while the resident was standing in front of the bed, the resident's knees buckled, and she lowered her to the floor. She called the nurse, and they assisted the resident back into bed. CNA #1 stated that the resident moaned at some point during the transfer. She added that she had always transferred the resident in this manner because that was how she had been taught when hired. She acknowledged being aware that the Kardex on the kiosk provided information on the resident's care needs and transfer status. She also confirmed that, during her orientation, she was instructed to check the Kardex at the beginning of each shift for any changes in the resident's needs or transfer requirements. CNA #1 admitted that she did not realize Resident #1 required a total lift for transfers because she had not checked the Kardex. She agreed that failing to follow the Kardex instructions could result in resident injury. Record review of the Admission Record revealed the facility admitted Resident #1 on 4/10/18 with diagnosis that include dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/25 revealed that Resident #1 has impaired range of motion (ROM) of lower extremities on both sides and maximal assistance for transfers.

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	03/26/2025

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 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. 47158 Based on staff interview, record review, and facility policy review the facility failed to implement a resident's care plan when Resident #1 was transferred without the required number of staff members and the use of the proper assistive devices for one (1) of three (3) residents care plans reviewed. Resident #1 Findings Include: Record review of the facility policy titled, Comprehensive Care Plans revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . A record review of the facility investigation revealed that on 3/14/25, while Resident #1 was being transferred to bed by Certified Nursing Assistant (CNA) #1, the resident stated, ow, and CNA #1 eased the resident to the floor. CNA #1 immediately notified the nurse. Upon evaluation, no injury or complaint of pain was noted. After assessing the resident, the Registered Nurse (RN) assisted her back to bed, identifying no apparent injury, bruising, or swelling. However, within 48 hours, swelling was observed above the right knee. An intervention was provided for comfort, and the physician was notified of the change in conditions. An X-ray revealed a fracture above the previous joint replacement device. The Nurse Practitioner (NP) and the Responsible Party were notified, and Resident #1 was transferred to the local emergency room for further evaluation and treatment. Record review of the Comprehensive Care plan for Resident #1 revealed, under Focus I have a physical functioning deficit with transfers and require assistance from team members and an (proper lift name) total lift. Under Interventions : (proper lift name) total lift with medium yellow sling .Two (2) members will assist with transfers with each episode On 3/26/25 at 9:15 AM, during an interview with the Administrator she verified that on the evening of 3/14/25, CNA #1 transferred Resident #1 to bed using a stand-pivot transfer method instead of a lift and had to lower the resident to the ground. During the transfer, the resident said, ow, but upon assessment by the RN, no injury was noted. She stated that within 48 hours, Resident #1 was moaning during care and an x-ray was ordered that showed the resident had a right femoral shaft fracture. A record review of a printout of the Kiosk Kardex for Resident #1 revealed the following: Safety .Two members will assist with transfers with each episode .Lift 4 Care: type of lift, sling size, etc. total lift with medium yellow sling. During an interview with CNA #2, CNA #3, and CNA #4 on 3/26/25 at 10:00 AM confirmed that the residents Kardex informed them of what the residents' care plans were and should be checked at the beginning of each shift. CNA #2, CNA #3, and CNA #4 all agreed that the Kardex would show how many staff were needed for a resident transfer and what type of lift to use based on the resident's care plan. (continued on next page)

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	03/26/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	On 3/26/25 at 11:32 AM, during a telephone interview with CNA #1 she confirmed that on the evening of 3/14/25 she transferred Resident #1 from the chair to the bed using the wrong type of lift method. She admitted that she did not look at or follow the residents' Kardex or care plan but used the stand pivot method of transfer instead of a total lift. She confirmed that when she stood the resident up and pivoted her to the bed, the resident's knees buckled, and she lowered her to the floor. During a follow-up interview with the Administrator on 3/26/25 at 12:00 PM, she stated that the care plan interventions for the total lift automatically pull to the Kardex kiosk for the CNAs to follow. She confirmed that it was her expectation that CNAs check the Kardex at the beginning of each shift and follow the care plan interventions. Record review of the Admission Record revealed the facility admitted Resident #1 on 4/10/18 with diagnoses that included dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/25 revealed that Resident #1 has impaired range of motion (ROM) of lower extremities on both sides and maximal assistance for transfers.