Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Eupora	156 E Walnut Ave Eupora, MS 39744

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 - Some	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** 46013 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure that a resident's rights were honored when a staff member refused to assist a resident with toileting for one (1) of four (4) survey days. Resident #2 Findings include: Review of the facility policy titled, Resident Rights & Quality of Life, with an effective date of March 13, 2020, revealed, .It is the policy that all residents and patients have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center . An observation and interview on 8/27/24 at 12:00 PM, revealed Resident #2 sitting in her wheelchair in her room. Resident #2 stated My bladder is about to bust. I've got to go to the bathroom so bad. I just returned from an appointment and haven't been to the bathroom since leaving the facility this morning. The resident was observed using her call light to ask for help. The resident stated they won't do it right now. They always say they can't while they are passing out trays. The resident kept urgently saying, Oh, I've got to go so bad. Resident #2 engaged her call light, and Registered Nurse (RN) #1 entered the room; the resident stated, Please, I've got to go to the bathroom so bad! Registered Nurse (RN)#1 stated to the resident, They can't right now. They are passing trays. When asked why they couldn't assist the resident in going to the bathroom, she stated, We've always been told we can't take anyone to the bathroom during meals or passing trays. Requested the Director of Nurses (DON) to come to the resident's room, so RN #1 left the room to go get the DON, but neither the nurse nor the DON came back to the room. An interview with the DON at 12:07 PM, in her office revealed we can't change or toilet residents while they are feeding other residents. She stated I will have to look at the cross-contamination policy as to the reason why. She revealed that she knew the resident had the right to go to the bathroom when needed, but that she would have to look at the policy first. The DON then instructed RN #1 to take the resident to the shower room to use the bathroom. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 8/27/24 at 12:20 PM, Certified Nurse Aide (CNA) #1 revealed we are not supposed to toilet residents during mealtimes. She stated it gets us in trouble with the residents because we have to tell them that we can't change them because we could get in trouble for doing it during mealtime. She revealed that we were told that it is a state thing and that if the state came into the building and we were changing someone or taking them to the bathroom, we would get in trouble. In an interview on 8/27/24 at 12:25 PM, CNA #8 revealed We have always been told that we are not allowed to take anyone to the bathroom or change anyone's briefs during mealtime. They have always just said because it is cross-contamination. In an interview on 8/27/24 at 2:20 PM, the DON revealed I have started doing in-services to all the staff on the floor and stated, Using the bathroom trumps everything; they have a right to be changed and assisted to the restroom at any time. Record review of Resident #2's Admission Record revealed an admitted [DATE] with medical diagnoses that included Overactive bladder,Type 2 Diabetes Mellitus, and Heart failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/24, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47874 Based on resident and staff interviews, record view, facility policy review, the facility failed to implement a care plan for nail care for Resident #41 and failed to develop a care plan for the application of leg braces for Resident #51 and failed to develop a behavior monitoring care plan for Resident #113 for three (3) of 26 resident care plans reviewed. Resident #41, #51 and #113 Findings include: Record review of facility policy titled, Care Plans dated October 2021, revealed, Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change. Resident #41 Review of the Care Plan undated for Resident #41 revealed, Self Care Deficit related to: decreased functional abilities, weakness. Also revealed, Nail, hair, and oral care daily and as needed. On 8/26/2024 at 11:36 AM, an observation of Resident #41 revealed, fingernails on both hands were long and measured approximately one-half (1/2) inch in length. On 8/27/2024 at 10:58 AM, an interview with Licensed Practical Nurse (LPN) #5, confirmed Resident #41's nails were long and needed to be cut. An interview with the Minimum Data Set (MDS) Nurse on 8/29/2024 at 8:51 AM revealed, the purpose of the care plan was for staff to know how to take care of the resident. She confirmed the care plan for nail care was not followed for Resident #41. Review of the Admission Record revealed the facility admitted Resident #41 on 10/26/2023 with a medical diagnoses that included Type 2 Diabetes mellitus with diabetic neuropathy. Resident #51 Record review of Resident #51's care plan revealed no care plan was developed for leg brace usage for the resident's range of motion needs. During an interview on 8/26/24 at 11:50 AM, Resident #51 stated he should be wearing leg braces two times a day to help the mobility in his legs, but the staff were not applying these. He stated he had recently completed therapy and they would pick him back up when his movement improved, but he needed the braces to help improve his limited range of motion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Physical Therapist (PT) on 8/27/24 at 2:35 PM, revealed the resident's therapy was discontinued on 8/23/24 and the team met to discuss the plan for the resident to continue to use the braces two times a day for one to one and a half hours each time. He stated he was unaware that resident had not worn these since therapy stopped last week and the braces are needed to regain his functional mobility and to increase his potential to walk. An interview with the Minimum Data Set (MDS) Coordinator on 8/29/24 at 8:45 AM revealed she was responsible for the development of the care plans. She confirmed the care plan for Resident #51's brace use was not developed due to a failure in the communication process for nursing to enter orders from the therapy department. She confirmed the care plan's purpose was to provide information on the care needed for the residents and the facility failed to develop a care plan for this resident's leg brace use. During an interview with the Director of Nursing (DON) on 8/29/24 at 9:15 AM, she confirmed the facility failed to develop a care plan for the brace usage for Resident #51. She confirmed there was a failure in their communication system and after the Nurse Practitioner signed the order for these braces, it was not received by nursing staff to put into their system and the care plan was not developed. An interview with the Administrator on 8/29/24 at 10:00 AM, revealed the facility failed to follow the process to enter the orders from therapy into their system for nursing service to follow, and a care plan was not developed. She confirmed the facility failed to ensure a care plan was developed for the resident's range of motion. Record review of Resident #51's Admission Record revealed the facility admitted the resident on 2/23/22. Diagnoses included Paraplegia, Muscle wasting and Atrophy. Record review of Resident #51's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/10/24, revealed a Brief Interview for Mental Status (BIMS) of 14 which indicated the resident was cognitively intact. Resident # 113 Record review of the Admission Record revealed the facility admitted Resident # 113 on 7/19/24 with a diagnosis of Type 2 Diabetes with Hyperglycemia and Schizophrenia and was readmitted on [DATE] with a diagnosis of Binge Eating Disorder. Review of the care plans for Resident #113 revealed there was not a care plan developed related to the diagnosis of Binge Eating Disorder. During a record review and interview with the Registered Nurse (RN) Director of Clinical services on 8/28/24 at 1:55 PM, she confirmed after reviewing the care plans for Resident #113 there was not a care plan developed related to Binge Eating. She stated the diagnosis must not have gotten picked up when she came back from the hospital on 8/14/24. In an interview with the Director of Nursing (DON) on 8/28/24 at 2:00 PM, she revealed after review of Resident # 113's care plans, there was no care plan developed related to the behavior of Binge Eating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the RN/MDS Coordinator on 8/28/24 at 3:45 PM, she revealed the purpose of the care plan is to accurately reflect the specific needs of a resident and staff can properly provide care for the residents. Record review of Resident # 113's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/24, Section C revealed a Brief Interview for Mental Status (BIMS) score was 5, indicating the resident was severely cognitively impaired. 41878 47157

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide personal hygiene as evidenced by failure to provide nail care for one (1) of 24 sampled residents. Resident #41 Findings Include: Review of the facility policy titled ADL's dated 8/2021 revealed Policy: Ensure ADL's (Activities of Daily Living) are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences . An observation and interview with Resident #41 on 8/26/2024 at 11:36 AM, revealed, she was sitting in her wheelchair in her room. She held up her hands and stated, I need my nails cut. I keep scratching myself. The resident revealed her nails had not been cut in a long time and stated she was a diabetic. The nails on both hands were long and measured approximately one-half (1/2) inch in length. An interview with Licensed Practical Nurse (LPN) #5 on 8/27/2024 at 10:58 AM, confirmed Resident #41's nails were long. She revealed that nail care had to be completed by a nurse since the resident was a diabetic. LPN #5 explained that diabetic nail care was not scheduled for the nurses to perform, it was just something the nurses did when it was needed. She confirmed long nails could cause a skin injury for the resident. An interview with the Director of Nursing (DON) on 8/27/2024 at 11:26 AM, confirmed diabetic nail care should be completed as part of the daily personal hygiene care. She revealed they did not have nail care set up on the Treatment Administration Record (TAR) for the nurses to perform, but her expectations were for the nail care to be performed when it was needed. Review of the Admission Record revealed the facility admitted Resident #41 on 10/26/2023 with a medical diagnosis of Type 2 diabetes mellitus with diabetic neuropathy. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #41 is moderately cognitively impaired.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

47157

Based on staff interview, record review, and facility policy review the facility failed to address dietary recommendations to change and/or increase a peg (percutaneous gastrostomy) tube feedings and water flushes to meet the nutritional needs for one (1) of three (3) residents reviewed who received enteral nutrition. (Resident #112)

Findings include:

A review of the policy titled Queuing RD (Registered Dietician) Recommendations & Follow-up, with an effective date of 7/1/21 revealed .Recommendations for changes to enteral feedings, enteral flush orders . is reviewed to ensure that the supervising physician is in agreement with nutrition therapy orders. The order is then signed, acknowledged and activated in the electronic medical record by a licensed nurse .

Record review of a Progress Note for Resident #112 by the RD dated 8/5/24 at 9:57 AM, revealed:

Note Text: Consult for tube feeding (TF) caloric intake:

CBW (Current body weight) 148.9. EEN (exclusive enteral nutrition) 1692-2030 kcal (kilocalorie).Glucerna 1. 2 237 cc (cubic centimeters) bolus with 200 ml (milliliters) water flushes provides 948 cc formula, 1127 kcal. Concerned that current orders are inadequate to meet the nutritional needs.

Recommend: 1.) Discontinue current TF/flush order. 2.) Start Glucerna 1.5 237 cc bolus five times a day with 100 cc flush before and after each bolus to provide 1185 cc formula, 1780 kcal, 100 grams protein, 900 cc plus medication flush 900 cc free water plus 1000 cc flush.

Record review of the Order Summary Report with active orders as of 8/9/24 revealed a physician's orders dated 8/02/24 Enteral Feed Order every 6 hours Glucerna 1.2 calorie (237 ml) bolus via peg tube with 200 ml water flushes.

An interview with the Director of Nursing (DON) on 8/29/24 at 8:00 AM revealed she was not notified of the RD's recommendations until 8/9/24 and the resident was no longer in the facility.

A phone interview with the RD on 8/29/24 at 8:35 AM, she revealed after review of her records she assessed Resident #112 on the morning of 8/5/24 and sent the recommendation to the interdisciplinary team email group the same morning at 10:12 AM.

A review of the email sent by the RD revealed the email to the Interdisciplinary team was documented as sent on 8/5/24 at 10:12 AM with recommendation for Resident #112.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview with the DON on 8/29/24 at 9:00 AM, revealed after review of the emails sent from the RD with the that she failed to see the recommendation for Resident #112 in the email on 8/5/24. She stated that she normally gets the dietary recommendations for tube feeders, obtains approval from the provider and writes the orders. She stated Licensed Practical Nurse (LPN) #1 also takes care of those recommendations. The DON then stated the provider should have been notified and the orders to change and increase tube feedings/flushes should have been written and carried out. An interview with LPN #1 on 8/29/24 at 9:15 AM, she confirmed she did get the email on 8/5/24 from the RD with the recommendations for Resident #112. She then stated that she only takes care of the dietary recommendations if the DON asks her to and confirmed the DON did not ask her to take care of Resident #112's RD recommendations. Review of the Admission Record revealed the facility admitted Resident #112 on 8/2/24 with diagnoses that included Cerebral Infarction and Encounter for attention gastrostomy.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interview, record review and facility behavior monitoring document review, the facility failed to ensure a resident with a new diagnosis of Binge Eating Disorder received appropriate behavioral monitoring and interventions to address the disorder for (1) one of (3) residents reviewed with behaviors. (Resident #113) Findings include: Review of a statement on facility letter head titled, Behavior Monitoring undated, revealed Specific behaviors are identified based on resident assessments. Behaviors are monitored by the nurses and quantitatively recorded in the medical record. Record review of the Admission Record revealed the facility admitted Resident # 113 on 7/19/24 with a diagnoses that included Type 2 Diabetes with Hyperglycemia and Schizophrenia. Resident #113 was readmitted on [DATE] with a new diagnosis of Binge Eating Disorder. In an interview with Certified Nurse Assistant (CNA) #2 on 8/27/24 at 2:00 PM, she revealed that Resident #113 was always wanting and looking for snacks and has been known to take food off the food carts. She stated that she was aware the resident was a diabetic and only gave her low sugar snacks when she wanted them. CNA #2 confirmed she was unaware of the diagnosis of Binge Eating Disorder. In an interview with Registered Nurse (RN) #2 on 8/28/24 at 8:00 AM, she revealed that Resident #113 was always hungry and asked for snacks and has been known to walk up to a tray cart and take food from the cart. In an interview with CNA #3 on 8/28/24 at 10:30 AM, she revealed she was unaware that Resident #113 had a Binge Eating Disorder. She then revealed the resident would take food from the desk or food cart and was always asking for more. Record review of the Medication Administration Record revealed an order dated 8/14/2024 Document number of episodes per shift of target behavior: 1. Hallucinations 2. Delusions 3. Paranoia 4. Aggressiveness 5. None . There was no monitoring for the Behavior of Binge Eating Disorder. During a record review and interview with Director of Clinical Services on 8/28/24 at 1:55 PM, she revealed after review of the Medication Administration Record for Resident #113, she was unable to find monitoring related to Binge Eating behavior. She stated the diagnosis must not have gotten picked up when she came back from the hospital on 8/14/24. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 8/28/24 at 2:00 PM, the Director of Nursing (DON) revealed after review of the Medication Administration Record for Resident #113 that there was no behavior monitoring in place for the Binge Eating Disorder diagnosis. She revealed she received that diagnosis when she returned from the hospital on 8/14/24. The DON confirmed Resident #113 should have been monitored for that behavior. She revealed the purpose of behavior monitoring is timely management of the behaviors. The DON then revealed that her binge eating could lead to elevated blood sugars. Record review of Resident # 113's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/24, Section C revealed a Brief Interview for Mental Status (BIMS) score was 5 indicating the resident was severely cognitively impaired.