| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255117 | A. Building<br>B. Wing | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Diversicare of Eupora | 156 E Walnut Ave<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878<br><br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to identify and provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care, and professional standards of practice to meet resident's physical needs for one (1) of five (5) residents reviewed for quality of care. Resident #3<br><br>Findings include:<br><br>Record review of facility policy titled, Notification of Change in Patient/Resident Health Status dated June 2017, revealed, Purpose: to ensure all interested parties are informed of the patient's/resident's change in health status so that a treatment plan can be developed which is in the best interest of the patient/resident . C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Depending on the nursing assessment appropriate notification may be immediate to 48 hours .<br><br>Record review of facility policy titled, Skin Care Guidelines, dated July 2018, revealed, Purpose: To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity . When an open area is identified: Implement resident specific interventions immediately . Notify physician and document notification.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 4/16/25 at 8:50 AM, Resident #3 stated she had been admitted to the facility on the afternoon of Friday, 3/21/25. She revealed she had been an insulin-dependent diabetic for several years and had been in the hospital due to cellulitis of a diabetic ulcer to the toe. She acknowledged she administered insulin three times daily prior to each meal and informed the facility nurse of this on admission and prior to her evening meal. She was informed that the doctor did not order her insulin when she was discharged from the hospital. She asked the nurse to notify the provider since she needed her insulin, and she had the continuous glucose monitoring (CGM) device and her blood sugars had not been low. She knew the provider did not discontinue her insulin and felt that the hospital made an error when reconciling her medications at discharge. This continued Saturday, Sunday, and Monday morning. The resident stated that the nurses refused to contact her physician for a clarification regarding her insulin. She stated she also had a diabetic ulcer on her toe and it was covered with a dressing on admission to the facility. She asked about dressing changes, but was told she did not have an order for wound care or dressing changes. She asked the nurse if she would contact the physician for an order for wound care as well as for insulin, but this was not done. The nurses did change the dressing on Saturday and on Sunday, but she was uncertain what they used for the treatment. She asked multiple people on Friday, Saturday, Sunday, and Monday morning about her insulin and wound care, but no one contacted the provider for orders for her needed care. The provider came in on Monday and ordered the wound treatment and was going to order insulin, but the resident told the provider she would continue to use her own insulin pen that she had brought from home since she was transferring to another facility that day or the next day and she did not want that added to her bill.<br><br>During an interview on 4/16/25 at 10:20 AM, the Registered Nurse Treatment Nurse stated he had left the building for the day when the resident was admitted from the hospital on 3/21/25 and he did not assess her until Monday 4/24/25. He stated the treatment being used was Hydrofera Blue so he spoke with the Nurse Practitioner and received a new order for collagen with silver for wound care. He stated if he was not in facility when a new resident was admitted , it was the nurses' responsibility to assess and document the wounds and he would measure and take pictures when he returned. He also stated the provider would be notified if the resident needed orders for care.<br><br>An interview with the Director of Nursing (DON) on 4/16/25 at 1:55 PM, revealed Resident #3 was admitted to the facility with a diabetic wound on Friday, 3/21/25. She acknowledged the resident had a diagnosis of Type 2 Diabetes Mellitus with long-term current use of insulin, and on the paperwork received from the hospital, her insulin was discontinued at discharge. The DON confirmed that the resident informed the staff that was a mistake and the physician needed to be contacted. Resident #3 had her own insulin pen and was administering her own medication even though the nurses informed her that that was a safety concern, and she had not been assessed for self-administration of medications. She stated a nurse attempted to contact the provider with no response and there was no documentation of this attempt. She acknowledged the Medical Director needed to be contacted if there was no response from other providers, but he was not contacted to verify orders for the insulin as well as for the wound care. She stated each resident in the facility had the right to the treatments and medications needed for their well-being and the facility failed to obtain orders for wound care and insulin and therefore, failed to give treatments and medications per those orders for this resident.<br><br>Record review of Resident #3's Clinical Summary revealed diagnoses of Insulin Dependent Diabetes Mellitus dated 8/15/18 and Type 2 Diabetes Mellitus with long term current use of insulin dated 12/24/24.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #3's History and Physical dated 3/18/25, revealed resident with history of .Type 2 Diabetes Mellitus with long-term current use of insulin. Blood glucose at that time was listed as 201 (High) with reference range of 70-110.<br><br>Record review of Resident #3's Discharge Summary with discharge date of [DATE], revealed discharge diagnosis of, Type 2 Diabetes Mellitus, with long-term current use of insulin.<br><br>Record review of Resident #3's Order Summary Report for March 2025, revealed an order dated 3/24/25 for Right great toe diabetic ulcer - clean wound with wound cleanser, pat dry with gauze, apply collagen with silver, cover with small piece of xeroform, secure with 2 x 2 bordered gauze, change daily. No order for insulin was noted on the Order Summary Report.<br><br>Record review of Resident #3's electronic Medication Administration Record (EMAR) for March 2025 revealed the resident had no insulin administrations listed or documented.<br><br>Record review of Resident #3's electronic Treatment Administration Record (ETAR) for March 2025 revealed the resident had a treatment to toe ordered on 3/24/25 and received this treatment on 3/25/25. No other treatments were listed or documented as done on the ETAR.<br><br>Record review of Resident #3's Progress Note dated 3/22/25 at 1400, revealed, Resident is self medicating herself with her own insulin. She is monitoring BS (blood sugar) with a device. Resident does not have an order for insulin. Charge nurse and Director of Nursing printed off orders and shown her that she was not on the insulin. Will continue to monitor.<br><br>Record review of Resident #3's Progress Notes Behavior Charting dated 3/24/25 at 0812 revealed, Describe Behavior/Mood, what the resident was doing, interventions attempted and effectiveness: Nurse went into resident's room this AM to check on resident. Resident was upset stating that her medication wasn't correct upon admit. Resident stated, I'm supposed to be on insulin. I need insulin due to my diagnosis of Diabetes Mellitus and I have to have my insulin. This nurse explained to resident that facility has to follow discharge orders that was sent with her when admitted . This nurse went over medications with resident. Resident then stated, 'they didn't notify me at the hospital that they discontinued my insulin'. This nurse assured resident that her medications would be assessed by Nurse Practitioner (NP) and primary physician. Resident then continued to state, 'That's okay, I have my own insulin that I've been giving myself and I'm keeping it. You're not gonna take it'. This nurse explained to resident that was unsafe. Resident then reported that she didn't care and was keeping her insulin. DNS (Director of Nursing Services)/Administration and NP aware.<br><br>Record review of Progress Note from Nurse Practitioner dated 3/24/25 at 22:59, revealed, per hospital documentation (Discharge Summary) patient has diagnosis of Type 2 Diabetes with long-term current use of insulin. Patient reports that she has been taking insulin for several years. However, per hospital documentation (After Visit Summary) under the Instructions section, stated for patient to STOP taking: Insulin Aspart 100 unit/milliliter injection (Novolog). Patient currently has a Insulin Aspart Injection Pen on her bedside table and states that she is using her pen to give herself insulin. Patient states, she takes Insulin Aspart 15 units before (AC) meals. Blood sugars noted with fluctuations. Ranging from 112-366 since admission on 3/21. NP offered to restart insulin. Patient states, no don't order me any insulin, I will just continue to use my own insulin, because I'm leaving today or tomorrow anyway.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Progress Note dated 3/24/25 at 12:57 revealed, Resident is alert and oriented sitting on side of the bed. Resident is incontinent of bowel/bladder. Resident stated that she giving herself her own insulin that she has in her room.<br><br>Record review of Clinical Health Status Evaluation dated 3/21/25, revealed, Barriers to Transition . Wound Care/Skin Integrity. Also, revealed, Self-Administration medications: Medication-Self Administration - Does the resident wish to self-administer medication? No.<br><br>Record review of Daily Skilled Nurses Note dated 3/22/25 and 3/23/25, revealed, Skin . c. Treatment (per orders/nurses note); d. dressing clean, dry, intact . Wound Observation Nursing Note (enter any other documentation related to wounds): Diabetic Ulcer to right great toe. No information of treatment documented.<br><br>Record review of Daily Skilled Nurses Note dated 3/24/25 revealed, Resident stated that she was giving herself her own insulin that she has in her room.<br><br>Record review of RN Treatment Nurse's documentation Skin and Wound Evaluation dated 3/24/25, revealed, Wound appears stable, callus noted to periwound, wound bed dry. Patient reports she has been using Hydrofera Blue as primary wound dressing. Report given to NP and new order received to clean wound with wound cleanser, pat dry with gauze, apply collagen with silver to wound bed, cover with small piece of xeroform, secure with 2 x 2 border dressing, change daily. Patient tolerated treatment well.<br><br>Record review of Resident #3's Admission Record revealed the facility admitted her on 3/21/25. Diagnoses included Type 2 diabetes Mellitus with foot ulcer and Cellulitis of right toe.<br><br>Record review of Resident #3's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. |