

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Diversicare of Eupora		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>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</p> <p>Findings include:</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 255117
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>47874</p> <p>Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve grievances related to food concerns and bed linens not being changed for five (5) of seven (7) residents with grievances. Resident #3, #19, #26, #88, and #108.</p> <p>Findings Include:</p> <p>Review of the Facility policy titled Customer Concern (Grievance) Policy dated 7/2018, revealed Purpose: Support each customer's (patient's/resident's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately apprised of its progress toward resolution .Process . The Administrator will ensure a thorough investigation is conducted and will respond to the customer (patient/resident) The Administrator shall follow up on the correction of the problem and finalize the Customer Concern Form validating the resolution of the concern including who did what, when, and where It is best practice for the Administrator to follow up with the customer after a period of time to ensure the customer remains satisfied with the concern resolution. This follow up should be recorded on the log. Maintaining evidence demonstrating the results of all grievances .</p> <p>Record review of the Customer Concern/Grievance Communication Form dated 7/30/2024 revealed Resident #26 filed a grievance regarding the quality of food services and presentation of meals specifically with egg salad. Revealed under, Steps Taken to investigate Concern: Spoke with Dietary Manger; staff educated on service, presentation of meals. The grievance was marked as resolved.</p> <p>An interview on 8/27/2024 at 11:45 AM, with Certified Nursing Assistant (CNA) #1 revealed the residents complain all the time about the food. I have told the residents to talk about it in resident council when they go, when they come back from resident council they will tell us that they told them about the food. She revealed it has been a problem and everyone knows about the food issues.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A resident council meeting was held on 8/27/2024 at 3:05 PM in which Resident #3, #19, #88, and #108 all revealed food concerns were discussed every month in resident council meetings, and they had not seen anything done to address their concerns. During the meeting Resident # 108 revealed the residents do not have food choices. She explained they had a set menu, and they can only get what was on the menu or two alternates to choose from every day, which is either a hamburger or a chicken sandwich. She stated, I'm a vegetarian and so is my roommate, and they don't have options for us. She revealed the food was disgusting and had no seasoning or flavor. Furthermore, she explained that she had been served lunch before and the next day was served the exact same thing for lunch and supper. She revealed the food was always cold and stated the vegetables were watery and ran together with other foods on the plate. Resident's #3 and #19 revealed the cornbread was so flat and hard there was no way to chew and swallow it. Resident # 88 revealed he was served mashed potatoes almost every day. He explained the vegetable medley and green beans were watery and agreed with Resident #108 that it merged with other foods on the plate. Resident#108 stated the food was as though they just threw something together and occasionally the foods were not cooked thoroughly. Resident #19 and #108 confirmed they had received foods that were not cooked thoroughly before. All resident voiced they had spoken about these food concerns in resident council with the Activity Director, the Dietary Manager and the Administrator in attendance. Resident #19 brought up his sheets were not being changed but about every 2 weeks. He revealed he asked them to change them, but usually, it does not get done because they say they are busy. Resident #108 stated her linens get changed only when her room gets deep cleaned which was twice monthly. The resident's voiced they would like to have their linen changed on their shower days.</p> <p>On 8/27/2024 at 4:07 PM, an interview with the Dietary Manager (DM) revealed, she was aware Resident #26 had complaints on the food. She explained they tried to accommodate everyone but thought it was the menu the residents did not like.</p> <p>An interview with Social Services (SS) #1 on 8/27/2024 at 4:20 PM revealed, Resident #26 had not voiced food concerns to her, but she was aware that the resident had voiced food concerns with several other facility staff members.</p> <p>An interview with the Administrator (ADM) on 8/28/2024 at 9:39 AM, revealed, Resident #26 was particular about her food and stated, she had talked to the resident a million times about her food issues. The ADM revealed that the resident even requested that she come and taste her food. She confirmed that she had not formerly filled out a grievance related to the resident's food concerns.</p> <p>Record review of the Resident Council Minutes dated 2/15/2024, revealed under, Old Business: Several stated sheets were still not being changed and were unsure of scheduled times to be changed. Activity Director then called for the Administrator to attend meeting, and she explained times the sheets are to be changed and answered all other concerns at this meeting with success. Also revealed under, New Business: Dietary: Several had likes and dislikes that they wanted updated. List of names given to the Dietary Manager in Dietary for review.</p> <p>Record review of the Resident Council Minutes dated 3/1/2024, revealed under, Old Business nothing was documented to address the previous concerns voiced in resident council meeting. Also revealed under, New Business: Dietary: Everyone went over some issues with Dietary Manager about seasoning on meat and potatoes. She talked with the residents about their concerns in meeting and all were ok.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Resident Council Minutes dated 4/5/2024, revealed under, Old Business nothing was documented to address the residents' concerns that were voiced in the previous meeting to ensure issues were resolved.</p> <p>An interview with Activity Director (AD) on 8/27/2024 at 3:22 PM confirmed the residents had been reporting food concerns in the resident council meetings. She explained that most of the concerns were regarding no seasoning or flavor on the food. She revealed Resident #108 had many special requests due to her diet choices of being a vegetarian. The AD revealed after the meetings she gave a copy of the meeting minutes to the Administrator and the Dietary Manager for the concerns to be addressed.</p> <p>An interview with the Dietary Manager on 8/27/2024 at 3:55 PM, revealed she was not aware of any recent concerns from the resident council meeting regarding food. She stated to her knowledge the residents were satisfied with the menu. The DM revealed the residents were allowed to choose between the meal on the menu or a hamburger or chicken sandwich. She confirmed she was aware of the resident complaints regarding a lack of variety of food choices.</p> <p>An interview with the Administrator on 8/27/2024 at 4:10 PM, revealed she was aware of the resident concerns regarding the food. She explained the residents did complain about the food for several months in resident council back in February and March 2024, but they did not mention it again in the April meeting. She confirmed a grievance was not completed and stated she instructed the Dietary Manager to go and speak with the residents and update their likes and dislikes. The ADM revealed they have a dietary contract with proper name and right now, they were working at the corporate level to find a solution to the food concerns.</p> <p>An interview with SS #1 on 8/28/2024 at 9:30 AM, revealed she goes to resident council meetings if she has time. She confirmed she was responsible for completing a grievance if a concern was brought to her. She revealed she was aware of the resident's food concerns and confirmed she did not complete a grievance. SS#1 stated a food complaint would be handled by the Dietary Department and revealed that the dietary usually goes and speaks with the resident to handle the concern. She revealed a food complaint would not be relevant to her position.</p> <p>An interview with the Administrator on 8/28/2024 at 1:40 PM, revealed she was aware of resident concerns regarding the linen not being changed but thought that issue was better. She explained the last time she was invited to resident council the residents told her the linen issue was better. She confirmed there was no documentation in the resident council meeting minutes that proved anything was done to address the resident's concerns regarding the linens not being changed.</p> <p>An interview with the Dietary Manager (DM) on 8/28/2024 at 2:06 PM, revealed when resident concerns were voiced in resident council about food, she personally went to speak with the residents in resident council. She confirmed that she did not have any documentation to show that the residents concerns were addressed and failed to follow up on to ensure the issues were resolved.</p> <p>Resident #3</p> <p>Review of the Admission Record revealed the facility admitted Resident #3 on 5/28/24 with medical diagnoses that included Type 2 diabetes mellitus without complications.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Admission Record revealed the facility admitted Resident #108 on 6/6/2024 with medical diagnoses that included Type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on staff interviews, record review, and facility policy review, the facility failed to accurately complete Section N of the Minimum Data Set (MDS) assessment for two (2) of twenty-six MDS reviewed. Resident #46 and Resident #96.</p> <p>Findings include:</p> <p>Record review of the facility policy titled, RAI Process Guideline dated September 2020, revealed,</p> <p>. All items in the MDS are to be coded per the instructions of the CMS Long-Term Care Facility Assessment User's Manual MDS 3.0 .</p> <p>Resident #46</p> <p>Record review of the MDS with an Assessment Reference Date (ARD) of 07/24/24, revealed under section N, Resident #46 received seven (7) days of Anticoagulant medication for the observation look back period of 7/18/24 through 7/24/24.</p> <p>Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #46 did not receive anticoagulant medication between 7/18/24 and 7/24/24.</p> <p>Record review of the Admission Record for Resident #46 revealed he was admitted to the facility on [DATE] with diagnoses that included Peripheral Vascular Disease, Tachycardia, and Atherosclerotic heart disease.</p> <p>Resident #96</p> <p>Record review of the MDS with an ARD of 07/20/24, revealed under section N, Resident #96 received seven (7) days of Anticoagulant medication for the observation look back period of 7/14/24 through 7/20/24.</p> <p>Record review of the MDS with an ARD of 07/20/24, revealed under section N, Resident #96 did not receive seven (7) days of Antibiotic medication for the observation look back period of 7/14/24 through 7/20/24.</p> <p>Record review of the eMAR for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #96 did not receive anticoagulant medication between 7/14/24 and 7/20/24.</p> <p>Record review of the eMAR for the MDS 7-day observation look-back period revealed Resident #96 received antibiotic medication between 7/14/24 and 7/20/24.</p> <p>Record review of the Admission Record for Resident #96 revealed he was admitted to the facility on [DATE] with diagnoses that included Cerebral infarction and Hyperlipidemia.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/28/24 at 8:50 AM, the MDS Coordinator confirmed that Resident #46 was coded on the 7-day look-back period for receiving an anticoagulant medication but had instead received an antiplatelet medication, which was coded in error. The MDS Coordinator confirmed that Resident #96 was coded on the 7-day look-back period for receiving an anticoagulant medication and was receiving an antiplatelet medication instead. She confirmed Resident #96 was on Macrobid, an antibiotic, and was not coded for antibiotic during that 7-day look-back period. The MDS Coordinator confirmed these were coded incorrectly by a remote MDS worker.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874</p> <p>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</p> <p>Findings include:</p> <p>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.</p> <p>Resident #41</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident #51</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident # 113</p> <p>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.</p> <p>Review of the care plans for Resident #113 revealed there was not a care plan developed related to the diagnosis of Binge Eating Disorder.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>41878</p> <p>47157</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>47874</p> <p>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</p> <p>Findings Include:</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41878</p> <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one (1) of three (3) residents reviewed for range of motion. Resident #51</p> <p>Findings include:</p> <p>Record review of facility policy titled, Splinting and Orthotics dated 9/5/17, revealed, It is the policy of (proper name of rehabilitation service) that therapist recommend, within their scope of practice, appropriate splinting and orthotics for patients currently receiving therapy services, as the need arises. For splinting/orthotic needs that the therapist deems outside their scope of practice or expertise, therapist will notify the facility and make appropriate referrals to outside sources Therapy personnel will work with the facility, patient and caregivers to recommend appropriate materials for fabrication/modification and/or to recommend prefabricated splinting/orthotic options. Once trained by therapy, the facility is responsible for implementing the wearing schedule to include donning/doffing (putting on/taking off) devices as recommended .</p> <p>In an interview on 8/26/24 at 11:50 AM, Resident #51 stated he was supposed to be wearing leg braces two times a day to help improve 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. He stated the braces are designed to gradually increase his ability to straighten his legs with his goal to eventually walk. He expressed his concern that he had told the staff that he needed his braces, but they had not applied since he completed therapy last week. Braces were observed to be in a box against the wall in the resident's room.</p> <p>Observations and interviews with the resident on 8/26/24 at 1:50 PM, 8/27/24 at 8:30 AM, 8/27/24 at 10:30 AM, and 8/27/24 at 2:20 PM revealed the braces were noted to be in the box in the same position as previously observed. Each interview of the resident revealed the staff had not applied the braces.</p> <p>During an interview with the Physical Therapist on 8/27/24 at 2:35 PM, revealed the resident's therapy was discontinued on 8/23/24 and the team met prior to discharge 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 acknowledged the time frame for the braces to be used was decided on based on the resident's preference for his daily activity choices since he was required to be in bed while wearing. 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.</p> <p>Interview with the Director of Nursing (DON) on 8/27/24 at 3:00 PM revealed she was unaware of the concern with the braces. She stated she did not see an active order for the use of the braces and the resident was not one to refuse care.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON at 3:40 PM on 08/27/24 she acknowledged she spoke with therapy and it appears the facility failed to put an order into the system when the resident was discontinued from therapy. She stated therapy had a plan of care and had in-serviced several nursing staff members on the splint use, but the staff failed to follow through and put the order in, therefore no tasks were entered for the staff to follow. She confirmed the facility failed to provide the resident with range of motion services to increase his mobility.</p> <p>An interview with Certified Nursing Assistant (CNA) #6 on 8/28/24 at 9:00 AM, revealed she worked with Resident #51 and had been trained on the use of the braces, but he had refused to put these on. She stated she worked 6 AM until 2 PM and when she came to work in the morning, she would attempt to put these on him and he declined. She reported this to the night shift nurse, but she did not report to the day shift nurse or go back to the resident later during her shift. She stated she was unaware that the reason to follow the time frame requirement was for the resident's preference for his day to day activities.</p> <p>During an interview on 8/28/24 at 9:45 AM, the Physical Therapy Assistant (PTA) revealed the facility staff failed to put the braces on the resident as required. She stated therapy and the resident worked out a schedule from 7:30 AM - 9:00 AM so he would be able to go to smoke break at 9:00 AM. He had to be lying in bed for the braces to be on, and he did not want to miss his smoke break. She stated he was being asked to put the braces on at 6:00 AM and he did not want these on at that time after it was agreed upon with therapy to have on at 7:30 AM. She stated he had been in therapy until last week and therapy had been ensuring the braces were used as ordered. She stated since his therapy was discontinued, they were unaware the staff members were not applying the braces. She stated the goal of these braces was for the resident to regain functional mobility to be able to meet his goal to stand and walk and this would offer him the chance to meet that goal as his range of motion improved.</p> <p>During an interview on 8/28/24 at 9:50 AM, Resident #51 stated, Thank you for getting' this done for me. I might not ever walk again, but this gives me a chance to be able to. He stated he was hopeful the system they now have in place would work so this would not happen again. He acknowledged the time frame that had been agreed upon would allow him to go outside to smoke. He stated he had to be in bed while he was wearing the braces, but that was not a problem as long as he could go to his smoke breaks. He then stated, Thank you very much! Resident observed lying in bed with braces on both legs.</p> <p>During an interview with the DON on 8/29/24 at 9:15 AM, she confirmed that after the Nurse Practitioner signed the order for these braces, it was not received by nursing staff to put into their system.</p> <p>An interview with the Administrator on 8/29/24 at 10:00 AM, revealed the facility failed to enter the orders from therapy into their system for nursing service to follow.</p> <p>Record review of Prescription-Standard Written Order dated 6/11/2024 revealed .Positional orthosis, Rigid Support right .and left .Medical Necessity: Pt (patient) is contractured, improves ROM (range of motion) .</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of In-service Training Report dated 7/2/24 with therapy training four nursing staff members on the knee brace/orthotics. Recommendation/approaches listed as Patient will wear knee braces and .orthotics twice daily (one time in morning and one time in afternoon) up to patient's tolerance with understanding that patient will doff orthotics. Preferably wear from 7:30 - 9:00 AM and 1:30 - 3:00 PM to improve patient's wearing tolerance to in turn improve patient's functional mobility tasks. This was signed by four nursing service staff members.</p> <p>Record review of Resident #51's Admission Record revealed the facility admitted the resident on 2/23/22 with diagnoses that included Paraplegia, Muscle wasting and Atrophy.</p> <p>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.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878</p> <p>Based on observation, resident and staff interviews, record review, and facility medication checklist review, the facility failed to store an inhalant medication in a locked storage compartment as evidenced by medication being left at the resident's bedside for one (1) of seven (7) medication observations. Resident #21</p> <p>Findings include:</p> <p>Record review of Performance Checklist Skill 21-1 Administering Oral Medications, dated 2014, revealed, . Implementation . l. Returned stock containers or unused medication to shelf or drawer, labeled cups and poured medications before leaving preparation area, did not leave drugs unattended.2. Administered medications . p. Stayed until patient/resident completely took all medication by the prescribed route .</p> <p>Record review of facility's letterhead, undated, revealed, (Proper name of facility) uses the Medication Administration Competency Checklist from [NAME] and [NAME] as a guideline for medication administration.</p> <p>During an interview with Resident #21 and an observation in resident's room on 8/26/24 at 10:50 AM, it was revealed that a respiratory inhaler Aerosol Solution device, was on resident's overbed table. The resident stated the nurse brought it in for him to use earlier and she left it at his bedside when she left the room.</p> <p>On 8/26/24 at 10:55 AM, an interview with Licensed Practical Nurse (LPN) #6 revealed she took the inhaler in Resident #21's room for him to use and after it was administered, she forgot to put it back into the locked medication cart. She stated she had been in-serviced on medication administration and was aware that medications should not be left at a resident's bedside and should be placed in the locked medication cart.</p> <p>During an interview on 8/26/24 at 11:35 AM, the Director of Nursing stated Resident #21 was assessed for medication administration with supervision, not independent medication administration. She stated a medication not being stored properly posed a risk for another individual to obtain the medication. She confirmed the facility failed to secure a medication in a locked cart.</p> <p>Record review of Order Summary Report with active orders as of 8/28/24 revealed an order dated 8/9/24 for Spiriva Respimat Inhalation Aerosol Solution . two inhalations inhale orally one time a day related to Chronic obstructive pulmonary disease.</p> <p>Record review of the Electronic Medication Administration record (eMAR) revealed on 8/26/24, the morning dose of Spiriva Inhaler was signed by LPN #6 as administered to Resident #21.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #21's Self-Administration of Medications, dated 5/15/23, revealed, Medications, 1a. Storage - with staff. This evaluation also revealed, 7. Physician Order . b. Resident may self-administer medications with supervision . date of order 11/15/22.</p> <p>Record review of Resident #21's Admission Record revealed the facility admitted the resident on 7/12/2017. Diagnoses included Chronic Obstructive Pulmonary Disease and Asthma.</p> <p>Record review of Resident #21's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874</p> <p>Based on observation, resident and staff interviews, record review and facility policy review the facility failed to ensure foods were palatable, attractive and at a safe and appetizing temperature, for seven (7) of 12 residents sampled for dining. Resident #19, #41, #52, #88, #101, #102, and #108.</p> <p>Findings include:</p> <p>Review of the facility policy titled Food: Quality and Palatability with a revision date of 9/2017 revealed Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs .</p> <p>Resident #19</p> <p>During the resident council meeting on 8/27/24 at 3:05 PM, Resident #19 revealed the cornbread was so flat and hard there was no way to chew and swallow it. Resident #19 confirmed he had received foods that were not cooked thoroughly before.</p> <p>Review of the Admission Record revealed the facility admitted Resident #19 on 12/23/2023 with a medical diagnosis of Mixed conductive and Sensorineural hearing loss.</p> <p>Review of the MDS with an ARD of 7/30/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #19 is cognitively intact.</p> <p>Resident #41</p> <p>An interview with Resident #41 on 8/26/2024 at 12:15 PM, revealed the facility did not fix the things she liked to eat. She explained that she liked rice with gravy, but they never added the gravy. She revealed she had spoken with the Dietary Manager, but the gravy continued to be an issue. Resident #41 stated the food tasted bad and had no flavor and she could not eat the food on most days.</p> <p>An observation and interview with Resident #41 during a lunch meal on 8/27/2024 at 12:10 PM, revealed the meal consisted of mashed potatoes, diced potatoes, a hamburger patty with Barbeque sauce on a bun. The resident revealed she did not think she needed two different potatoes and the bun due to being a diabetic.</p> <p>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.</p> <p>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.</p> <p>Resident #52</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Resident #52 on 8/26/2024 at 1:38 PM revealed the food tasted bad. He stated he could ask for something else, but you probably couldn't eat it either. He explained that he got a hamburger every night because what they cooked at night was awful. The resident confirmed he had told the Dietary Manager, and he had told staff in resident council meeting and revealed nothing ever gets done.</p> <p>Review of the Admission Record revealed the facility admitted Resident #52 on 9/23/2022 with medical diagnoses that included Bipolar disorder.</p> <p>Review of the Quarterly MDS with an ARD of 7/18/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #52 is cognitively intact.</p> <p>Resident #101</p> <p>An interview with Resident #101 on 8/27/2024 at 8:41 AM, revealed the food tasted terrible and was cold. He explained the food was not cooked right and the chicken was not cooked thoroughly. He stated, It looks like they just throw some things together to make a meal. The resident stated they need more options for food and revealed the only thing they can get besides the main meal was a hamburger or chicken sandwich.</p> <p>An observation of Resident #101 lunch meal on 8/28/2024 at 12:15 PM, revealed the resident sent his tray back with the aide to be warmed up in the microwave due to being cold. Resident #101 received 2 hamburgers on buns, diced potatoes and a blueberry muffin.</p> <p>Review of the Admission Record revealed the facility admitted Resident #101 on 8/6/2024 with a medical diagnosis of Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema</p> <p>Review of the Quarterly MDS with an ARD of 8/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #101 is cognitively intact.</p> <p>Resident #102</p> <p>An observation and interview on 8/26/24 at 11:50 AM, revealed Resident #102 sitting up on the side of her bed eating her lunch which consisted of a ham pasta, creamed spinach, bread, fruit cup, and water. Observed only eaten a small amount of lunch at that time. She stated she did not like the food and even though there are alternate items, she often does not order these in time to receive. She stated the food is bland and not seasoned and it's just not good and she kept snacks available so she would have something to eat. She stated she had talked to the Dietary Manager about her likes and dislikes, but even if an item is on her likes list, it still does not taste good.</p> <p>An observation and interview on 8/27/24 at 11:40 AM, revealed Resident #102 sitting up on side of her bed eating her lunch which consisted of a chunky chicken salad sandwich (which she had eaten approximately 95% of), cubes potatoes that were not browned (appeared to be the full serving still on plate), [NAME] slaw (full cup remained), chocolate chip cookie, and water. Meal ticket revealed a tuna salad sandwich was served which was incorrect. She stated the food was not good. Resident #102 stated the potatoes were not tender or fully cooked and the [NAME] slaw tasted ruined or was leftover and too much mayonnaise was added.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Diversicare of Eupora		STREET ADDRESS, CITY, STATE, ZIP CODE 156 E Walnut Ave Eupora, MS 39744	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/27/24 at 2:50 PM, the Dietary Manager revealed both tuna and chicken salad were served for lunch so the wrong item was served. The Dietary Manager stated she had talked to the resident about her preferences and likes and dislikes and options she would like to use as substitute items. She confirmed there had been concerns about the food expressed to her by this resident and other residents.</p> <p>A sample tray was received from the kitchen on 8/27/24 at 11:35 AM. The food consisted of a barbeque hamburger patty on a bun, diced (hash brown cube like) potatoes, salad with lettuce and a slice of tomato, [NAME] slaw, cookie, tea. Hamburger patty sampled and was not warm and the flavor was bland. The [NAME] slaw was sampled by State Agency and noted too much mayonnaise was in the [NAME] slaw. The flavor tasted like eating mayonnaise from the jar. The potatoes were not warm and were not browned on the outside or tender on the inside.</p> <p>Record review of Resident #102's Admission Record revealed the facility admitted the resident initially on 12/5/23 with the most recent admitted [DATE]. Diagnoses included Type 2 Diabetes Mellitus and Gastro-esophageal reflux disease.</p> <p>Record review of Resident #102's MDS with and ARD of 7/3/24, revealed a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Resident #108</p> <p>During the resident council meeting on 8/27/24 at 3:05 PM, Resident # 108 revealed the residents do not have food choices. She explained they had a set menu, and they can only get what was on the menu or two alternates to choose from every day, which is either a hamburger or a chicken sandwich. She stated, I'm a vegetarian and so is my roommate, and they don't have options for us. She revealed the food was disgusting and had no seasoning or flavor. Furthermore, she explained that she had been served lunch before and the next day was served the exact same thing for lunch and supper. She revealed the food was always cold and stated the vegetables were watery and ran together with other foods on the plate. Resident#108 stated the food was as though they just threw something together and occasionally the foods were not cooked thoroughly.</p> <p>Review of the Admission Record revealed the facility admitted Resident #108 on 6/6/2024 with a medical diagnosis of type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.</p> <p>41878</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>47874</p> <p>Based on resident and staff interviews and snack program document review, the facility failed to provide residents with a bedtime snack for six (6) of six (6) residents interviewed during the resident council meeting. Resident #3, #13, #19, #88, #94, and #108</p> <p>Findings Include:</p> <p>Review of the H.S. (Bedtime) Basic Snack Program: Evening undated, revealed, Basic snack program items delivered between 7:30 pm -8:00 pm. Bulk snack cart should include (2-3) basic choices for the residents.</p> <p>A resident council meeting was held on 8/27/2024 at 3:05 PM, in which Resident #3, #13, #19, #88, #94, and #108 revealed they were not receiving a bedtime snack. Resident #88 revealed the kitchen did bring snacks out at night, but they left them at the desk and they were not passed out to the residents. He revealed the residents that were able to go to the desk had been getting their snacks. He stated, So it's first come, first served. He revealed if a resident was not mobile, they would not get a snack because they do not bring them to the rooms. Residents #3, #88, and #108 confirmed they were diabetics and all other residents in attendance agreed they would like a bedtime snack.</p> <p>An interview with the Administrator (ADM) on 8/27/2024 at 4:10 PM, revealed she was not aware that the residents were not getting a bedtime snack. She explained, that the kitchen was sending out individual snacks to the floor with a resident's name, but they had stopped doing that. She confirmed the diabetics needed a bedtime snack to ensure they did not experience low blood sugar.</p> <p>An interview with the Dietary Manager on 8/28/24 at 2:06 PM, revealed the kitchen did send out bulk bedtime snacks to the nurse's desk where the residents could grab and go, and the aides were responsible for passing them out.</p> <p>An interview with Registered Nurse (RN) #2 on 8/29/24 at 8:41 AM, revealed she worked 7 PM to 7 AM shift. She stated the kitchen brings the bedtime snacks to the nurse's station and most of the time the residents will come to the desk and ask for a snack.</p> <p>Resident #3</p> <p>Review of the Admission Record revealed the facility admitted Resident #3 on 5/28/24 with diagnoses that included Type 2 diabetes mellitus without complications.</p> <p>Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/6/2024 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicates Resident #3 is moderately cognitively impaired.</p> <p>Resident #13</p> <p>(continued on next page)</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admission Record revealed the facility admitted Resident #13 on 5/29/2021 with diagnoses that included Type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>Review of the MDS with an ARD of 6/19/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #13 is moderately cognitively impaired.</p> <p>Resident #19</p> <p>Review of the Admission Record revealed the facility admitted Resident #19 on 12/23/2023 with diagnoses that included Mixed conductive and sensorineural hearing loss.</p> <p>Review of the MDS with an ARD of 7/30/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #19 is cognitively intact.</p> <p>Resident #88</p> <p>Review of the Admission Record revealed the facility admitted Resident #88 on 2/9/2023 with diagnoses that included Type 2 diabetes mellitus without complications.</p> <p>Review of the MDS with an ARD of 7/18/2024 revealed, under section C, a BIMS summary score of 15, which indicates Resident #88 is cognitively intact.</p> <p>Resident #94</p> <p>Review of the Admission Record revealed the facility admitted Resident #94 on 9/29/2023 with a medical diagnosis of Unspecified dementia.</p> <p>Review of the MDS with an ARD of 6/6/2024 revealed under section C, a BIMS summary score of 14, which indicates Resident #94 is cognitively intact.</p> <p>Resident #108</p> <p>Review of the Admission Record revealed the facility admitted Resident #108 on 6/6/2024 with diagnoses that included Type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the MDS with an ARD of 6/13/2024 revealed under section C, a BIMS summary score of 15, which indicates Resident #108 is cognitively intact.</p>		