STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306 Based on interviews, record review, and facility policy review, the facility failed to ensure effective and timely pain management for one (1) of three (3) sampled residents (Resident #5) with multiple cancer diagnoses, including lung, pancreatic, rectal, and glottic cancer and was admitted with physician orders for scheduled and as-needed (PRN) opioid analgesics but did not receive PRN pain medication for approximately twelve (12) hours following his admission, which resulted in unmanaged pain. Findings include: A review of the facility policy titled Pain Management, dated January 2021, revealed, .To provide guidelines for consistent evaluation, management and documentation of pain in order to provide maximum comfort and enhanced quality of life .Upon admission pain is evaluated .Findings are recorded in the EMR (Electronic Medical Record) .Physician notification occurs as indicated for communication of findings and review of need for pharmacological options . A record review of the Admission Record, revealed the facility admitted Resident #5 on 2/14/25 and he had diagnoses including Malignant Neoplasm of Rectum, Pancreas, Glottis, and Bronchus or Lung. A record review of the After Visit Summary from the acute hospital, dated 2/14/25, revealed Instructions included to start fentaNYL Start taking on: February 15, 2025 and HYDROmorphone (Dilaudid). The medication list included fentaNYL 50 mcg (last time patch was given was on 2/12/25) and HYDROmorphone 4 mg every four (4) hours as needed. These orders were received by the facility on 2/14/25 at 2:40 PM. A record review of Resident pain level documented on 2/15/25 at 4:52 AM was three (3). A record review of the Nurse Practioner (NP) note, dated 2/15/25, signed at 10:17 AM revealed, Chief Complaint/Reason for this Visit was new patient needs pain medication .New patient; admitted last night complaints of pain all over. History of cancer; lung. Has a prescription for dilaudid but it is not available at this time. Resident has a fentanyl patch in use with no relief of pain .Nurse reports that his medications should be arrive tomorrow but resident needs relief now .Orders for this visit Norco 10-325 mg (milligrams) take one tablet by PEG (Percutaneous Endoscopic Gastrostomy) every 12 hours x (times) 2 doses. (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 0697 Level of Harm - Actual harm Residents Affected - Few	A record review of the Transactions by Patient report revealed LPN #1 removed Hydrocodone 10 mg for Resident #5 on 2/15/25 at 10:46 AM. A record review of the acute care hospital admission records, dated 2/15/25, revealed Resident #5 was, . significant for .lung cancer, rectal cancer, and pancreatic cancer. He has chronic back pain and the right lower extremity pain for which he is on analgesic. He returned because of worsening pain back and right hip. Pain medications were not controlling his pain enough .Patient ultimately succumbed to his illness on 02/20/2025 . On 3/11/25 at 11:15 AM, during a phone interview with one of Resident #5's family members revealed the resident was admitted to the facility late on 2/14/25 at approximately 10:30 PM, and the facility did not have his pain medication available until the next day on 2/15/25 at around 11:00 AM. She revealed her brother had cancer throughout his body and complained of pain frequently. During a phone interview on 3/13/25 at 10:14 AM, with License Practical Nurse (LPN) #1 confirmed that the facility did not have the written prescription of hydromorphone in their emergency medications. She reported to work on 2/15/25 at 7:00 AM, the resident's family member informed her of Resident #5's pain, after realizing the facility did not have the medication. She notified the Nurse Practioner (NP) on call, who returned her call to request a pain medication for the resident. The NP ordered Hydrocodone-Apap 10-325 MG for the resident. On 2/15/25 at 10:46 AM, LPN #1 removed the medication from the emergency medication and administered to the resident. He was later transferred to the hospital for evaluation and treatment due to his pulse oximetry was dropping. On 3/13/25 at 10:21 AM, during an interview with the Director of Nurses (DON), she confirmed that she was aware of Resident #5 being admitted to the facility on [DATE] with a hard copy (written) prescription for hydromorphone (Dilaudid). The facility expected for him to arrive at the facility earlier so that the medication would have been delivered by their pharmacy. The DON revealed there was a delay in the resident receiving his pain medication due to their emergency medication did not have his prescribed medication of Dilaudid. The staff contacted the NP on 2/15/25 to obtain an order for pain medication that they kept at the facility. On 3/13/25 at 3:00 PM, an interview with the Administrator confirmed that the facility policy is to administer pain medication as requested, that the facility failed to give the medication at the requested time, which caused a delay in treatment. On 3/17/25 at 1:00 PM, during a post exit phone interview with Resident #5's other family member, she stated she was at the facility on 2/15/25, at approximately 7:30 AM and the resident stated that he was in pain all night and he was calling out in pain. She stated that his face was red, agitated, and he was coughing. She went to the nurses' station and the night nurse reported that they did not have his medication in the facility, but that they were in the process of contacting the NP to obtain another prescription for a pain medication. The family member reported that she was walking up and down the hall, waiting for the nurse to obtain the resident's pain medication. The family member also reported they brought it to him around 11:00 AM, and Resident #5 kept asking her to take him to the hospital because of his pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 3/17/25 at 2:00 PM, during a post exit phone interview, LPN #2, confirmed that on 2/14/25 she worked the night shift and Resident #5 entered the facility around 8:30 PM, with a hard copy prescription for Dilaudid. She reported that she observed Resident #5 sleeping frequently during the night and he did not complain of pain or use his call light. She revealed that she was not aware that she could have contacted the on-call NP during the night for a pain prescription for medication kept in the emergency kit. LPN #2 stated that a family member came to the facility on [DATE] and reported that Resident #5 was in pain.