STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255293	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Shelby	1108 Church Street Shelby, MS 38774

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on observation, staff interview, and facility policy review the facility failed to provide blinds or window coverings in good repair for one (1) of 60 resident rooms observed for a clean, comfortable, and homelike environment. room [ROOM NUMBER]. Findings Include: Review of the facility policy Work Orders and Paging, effective September 1, 2014, revealed, Purpose, To establish a productive procedure for communicating and coordinating the needs of the residents and employees from the Maintenance Department . Work Orders, TELS . is a Computerized Maintenance Management System (CMMS). Employees shall complete Work Orders through TELS. When a verbal request for maintenance is received from center personnel, maintenance staff should request that a work order be submitted . An observation of room [ROOM NUMBER] on 5/19/24 at 1:00 PM, revealed the window blind had broken slats creating a 12 by six (6) inch opening on the right side through which the parking lot was visible. In an interview on 5/20/24 at 9:35 AM, with Certified Nursing Assistant (CNA) #1 she stated that if there was something broken in a resident's room, she would tell the maintenance staff. During an interview on 5/20/24 at 9:40 AM, with Registered Nurse (RN) #1 he stated that if broken equipment was found in the resident room, he would notify the maintenance staff either in person or by phone. On 5/20/24 at 10:00 AM, an observation of room [ROOM NUMBER] and interview with the Maintenance man, he verified that the window blinds were broken creating and opening on the right side. The Maintenance man stated that staff are supposed to enter work orders in TELS, but usually they just tell him. He verified that he was not aware of the condition of the window blinds. On 5/20/24 at 10:07 AM, an interview and record review, with the Maintenance man, of work orders in TELS, revealed that there was no work order for the broken window blinds in room [ROOM NUMBER]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 5/20/24 at 2:00 PM, she stated that staff usually notify the Maintenance man verbally or put maintenance needs on the 24-hour report. She verified that staff have not consistently been entering maintenance requests in TELS like they should.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately complete section P of the Minimum Data Set (MDS) for one (1) of four (4) residents residing in the facility with a wander alert bracelet. Resident #24 Findings Include: Review of the facility policy titled RAI (Resident Assessment Instrument) Process Guideline undated, revealed Process: The CMS (Centers for Medicare and Medicaid Services) Long-Term Care Facility Resident Assessment User's Manual 3.0 will provide the framework and directions to completing the RAI process. 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. An observation of Resident #24, on 5/19/2024 at 12:16 PM, revealed she was sitting on the edge of the bed. A wander alert bracelet was observed on her left ankle. Record review of the Order Summary Report with active orders as of 5/20/24, revealed an order dated 7/03/2023, Wanderguard to left ankle. Check placement and function Record review of Resident #24's quarterly MDS with an Assessment Reference Date (ARD) of 5/3/2024, revealed in Section PO200 Alarms .Wander/elopement alarm was coded as 0 indicating Not used during the MDS look back period An interview with the MDS Nurse on 5/20/2024 at 11:01 AM confirmed a data error was made on Resident #24's quarterly MDS and the wanderguard was not captured. An interview with the Director of Nursing (DON) on 5/20/2024 at 11:06 AM, revealed her expectations was for the assessments to be completed accurately by the MDS staff.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident receiving an enteral feeding (Resident #1), and failed to develop a comprehensive care plan for a resident receiving antipsychotic medication (Resident #54) for two (2) of nineteen care plans reviewed. Findings Include: Review of the facility policy titled Care Plans with a revision date of October 2021 revealed, Policy: 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. This document was dated 5/21/24 and signed by the Licensed Nursing Home Administrator. Resident #1 Record review of Resident #1's care plan revealed, Focus: (Proper name of Resident #1) has PEG (Percutaneous Endoscopic Gastrostomy) tube placed and is at risk for complications R/T (related to) feeding tube .Interventions . every shift Jevity 1.5 @ (at) 65 ml/hr (milliliters per hour) x (times) 22 hours, 2145 kcal (kilocalories); 90g (grams) protein; and 2330 ml total fluid. An observation on 5/19/2024 at 12:25 PM, revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 enteral feeding was hanging via feeding pump, which was turned off. An observation on 5/19/2024 at 3:15 PM revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 enteral feeding was hanging via pump, which was turned off. On 5/19/2024 at 3:55 PM, in an interview with Licensed Practical Nurse (LPN) # 2 confirmed Resident #1's feeding pump was turned off. On 5/21/2024 at 3:30 PM, in an interview with the Director of Nursing (DON) revealed the purpose of the care plan was to identify and focus on the resident's concern or problem and to develop interventions to resolve the problem. She confirmed that the facility did not follow Resident #1's care plan for the enteral feeding. Resident #54 An observation of resident #54 on 5/19/2024 at 2:35 PM, revealed she could be heard hollering down the hallway. The resident was sitting in a wheelchair in her room and was confused, asking for the car keys and stated she was leaving to go to the store but did not want anyone to know. Record review of the Order Summary Report with active orders as of 5/20/24, for Resident #54 revealed an order dated 4/22/2024, Seroquel oral tablet 50 MG (milligrams) (Quetiapine Fumarate) Give 50 mg via PEG-Tube at bedtime for Mood Disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Care Plans for Resident #54 revealed a care plan was not developed for the antipsychotic medication Seroquel for mood disorder. An interview with the Minimum Data Set (MDS) nurse on 5/20/2024 at 1:15 PM, revealed she was responsible for the care plans. She confirmed Resident #54 did not have a care plan developed for the antipsychotic medication Seroquel. She revealed a care plan should have been developed so that staff would know what care to provide. An interview with the Administrator (ADM) on 5/20/2024 at 1:32 PM, revealed antipsychotic medications should be care planned because they were high-risk medications and it would allow staff the knowledge to provide better care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47874 Based on observation, staff interview, and record review and facility document review, the facility failed to ensure a resident who received enteral nutrition received appropriate treatment and services, as evidenced by, the facility's failure to administer an enteral feeding according to the physician's order for one (1) of 11 residents with a feeding tube. Resident #1 Findings Include: Record review of a typed document on facility letterhead, dated 5/21/24 and signed by the Licensed Nursing Home Administrator revealed, Standards of Practice: The expectation set forth by (Proper Name of the facility) is that nurses comply with current standards of practice in terms of following physician's orders. This includes following orders for medication and enteral feedings. An observation on 5/19/2024 at 12:25 PM, revealed Resident #1 with his eyes closed lying in bed A bottle of Jevity 1.5 was hanging via pump, which was turned off. An observation on 5/19/2024 at 3:15 PM, revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 was hanging via pump, which was turned off. An interview with Licensed Practical Nurse (LPN) #2 on 5/19/2024 at 3:55 PM, confirmed Resident #1's enteral feeding was turned off. Record review of the May 2024 MAR for Resident #1 revealed an order dated 3/12/2024, Enteral feed one time a day turn feeding pump off scheduled for 7:00 AM, signed as administered on the MAR, which indicated the resident was receiving this order. An additional order dated 3/12/2024 revealed, Enteral Feed Order one time a day turn feeding pump on scheduled for 1500 (3:00 PM) signed off as administered on the MAR, which indicated the resident was receiving this order. Record review of the May 2024 Medication Administration Record (MAR) for Resident #1 revealed an order dated 5/7/2024, Enteral feed order every shift Jevity 1.5 @ 65 ml/hr (milliliters per hour) x (times) 22 hours, 2145 kcal (kilocalories); 90g (grams) protein; 2330 ml (milliliter) total fluid which was signed off on the MAR as administered, which indicated the resident was receiving this order. During an interview with the Director of Nursing (DON) on 5/20/2024 at 8:45 AM revealed several weeks ago Resident #1 began not eating meals, and they increased his tube feeding. She revealed he was supposed to be receiving Jevity1.5 at 65 ML/HR (milliliters per hour) x (times) 22 hours. She confirmed the Jevity was not supposed to be off between the hours of 7:00 AM to 3:00 PM and stated the order should have been discontinued. The DON revealed an error was made by not removing the order from the resident's MAR. She revealed she took responsibility for the error because she put the new feeding order into the medical record and did not take out the other discontinued order. She confirmed weight loss could be a concern. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse (RN) #1 on 5/21/2024 at 9:02 AM, confirmed he was aware Resident #1 had two enteral feeding orders on the MAR. He revealed there was a problem with communication and the old order was not discontinued. He stated he had been turning the resident's feeding pump off at 7:00 AM and re-starting it at 3:00 PM daily, and confirmed he was signing both orders. RN #1 revealed he should have questioned the order and called the doctor for clarification and confirmed he should not sign a physician's order on the medical record that was not given. He revealed that the resident was at risk for dehydration, weight loss and malnutrition by not getting the appropriate enteral feeding. An interview with the Administrator (ADM) on 5/21/2024 at 9:48 AM, revealed the nurses should have questioned two different enteral feeding orders on the MAR. She revealed they should not have signed both orders as administered, and confirmed this was a standard of practice issue. She acknowledged Resident #1 was at risk for weight loss by not getting the correct enteral feeding order. During a telephone interview with the Registered Dietician (RD) on 5/21/2024 at 10:22 AM, confirmed Resident #1 was at risk for weight loss if he did not get the prescribed enteral feeding. Record review of the Admission Record revealed the facility admitted Resident #1 on 9/8/2019 with current medical diagnoses that included Alzheimer's Disease, Dysphagia, and Gastrostomy status.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47874 Based on staff interviews, record review and facility document review, the facility failed to submit accurate staffing information into the Payroll-Based Journal (PBJ) system for one (1) of four quarters reviewed. First quarter 2024 Findings Include: Record review of a typed document on facility letterhead, dated 5/21/24 and signed by the Licensed Nursing Home Administrator (LNHA) revealed Staffing: It is the practice of (Proper name of the facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staffing expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment. The center conducts work force management meetings daily to discuss open positions, open shifts and call ins as related to patient needs. We continue to actively recruit staff offering various incentives. Record review of the PBJ (Payroll-Based Journal) Staffing Data Report revealed the facility submitted excessively low weekend staffing data for the 1st quarter 2024 (October 1-December 31). An interview with Licensed Practical Nurse (LPN) #3 on 5/19/2024 at 12:45 PM, revealed she had witnessed staffing concerns on the weekend and stated they mostly come from call in's. She revealed management did come in to work when someone called in. An interview with LPN #2 on 5/19/2024 at 12:50 PM, revealed she had witnessed staffing concerns on the weekend. She explained that when someone calls in on the weekend, they get on the phone and start calling staff to find help. She revealed they also notify the Workforce Manager so that she can start making calls. LPN #2 explained that management always helps and comes to work when someone calls in. An interview with the Administrator (ADM) and the Director of Nursing (DON) on 5/19/2024 at 3:30 PM, revealed they were not aware they had triggered for low weekend staffing. The ADM revealed they have a Workforce Manager who always ensured the facility met the minimum requirement or above. She stated they had never fallen below that minimum requirement. She revealed they do have frequent call-ins, but all management personnel come to work to fill positions, whether it be as an aide or a nurse. The ADM stated they all rotated and took call and were responsible for coming in if they were unable to find replacement staff when someone called in. The DON revealed that management personnel were all salaried and that corporate did not have a way to add them to the PBJ (Payroll-based Journal) because they did not clock in. The ADM explained that she had several discussions with the facility Human Resource staff member and the Corporate Payroll staff and was told there was no way to add any hours for coming in and covering a shift for salaried individuals. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the Workforce Manager on 5/20/2024 at 2:32 PM, revealed she had worked in the staffing position for two (2) years. She revealed call in's were the biggest concern for staffing. She stated they have a staff member on call every day. She explained when a staff member called in, they had to call in to the person on call, and it was the on-call person's responsibility to call around and try to find a replacement. She revealed on the weekends, they call in to the facility and the floor nurses were responsible for calling the staff to find a replacement. The Workforce Manager explained the on-call person must work if they cannot find someone. She stated when management worked to fill a position, she always included them in her staffing numbers even though she knew Human Resources had told her that they were unable to add it to the payroll data. She confirmed this was an error in payroll data submission. An interview with the ADM on 5/20/2024 at 3:15 PM, revealed she just hired two (2) aides and was looking to hire 2 more part-time. She stated the staff she has right now were willing to work extra and stay over to cover shifts. She revealed all management personnel come in to work to meet the staffing requirement when someone calls in. She explained she had reached out to the corporate office to notify them of the need to count salaried employees on payroll but was told they did not have a way to do it. She confirmed this was a payroll data error and would not accurately reflect the staffing numbers. An interview with Human Resources on 5/21/2024 at 9:40 AM, revealed she was responsible for completing payroll. She revealed once her information was entered into the payroll system, it went to the corporate office. She explained that the payroll system will not allow her to change the role of a salaried employee. She revealed that salaried employees' hours were pre-set in the system and could not be changed. An interview with the ADM on 5/22/2024 at 9:10 AM, revealed that the facility was without a payroll person for 4-5 months, and that would have been during the time the facility triggered for low weekend staffing. She revealed she hired someone in the middle of October 2023 to fill that position but the new hire still had to be trained. She explained that she and the Workforce Manager did payroll within that time frame. She revealed she was not familiar with payroll, but she had to step up and do what needed to be done. She acknowledged this likely caused some data errors with the accurate submission of the payroll-based Journal.