

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Diversicare of Copper Basin		STREET ADDRESS, CITY, STATE, ZIP CODE  166 Industrial Drive Copperhill, TN 37317	
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51371</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure resident health information remained private and confidential for 1 resident (Resident #28) of 4 residents observed during medication administration, which had the potential to allow unauthorized individuals access to the residents's private health information.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Protected Health Information (PHI), Management and Protection, revealed .It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure .</p> <p>Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, and Muscle Weakness.</p> <p>During an observation and interview on 3/25/2025 at 8:29 AM, on the B hall, revealed Licensed Practical Nurse (LPN) A walked away from the medication cart to enter Resident #28's room and left the computer screen unlocked which revealed Resident #28's private health information. Further observation revealed LPN A returned to the medication cart at 8:31 AM. LPN A stated she .forgot . to ensure the computer screen was locked and covered before leaving the medication cart. LPN A confirmed Resident #28's private health information was not protected and was available for the public to view.</p> <p>During an interview on 3/25/2025 at 2:11 PM, the Administrator stated when a staff member accessed the electronic medical record by computer, the staff member should ensure the computer screen was locked and covered to maintain the residents' privacy. The Administrator confirmed Resident #28's private health information was not protected on the B hall when LPN A failed to ensure the computer screen was locked and covered prior to leaving the medication cart.</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
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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49786</p> <p>Based on review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, observation and interview the facility failed to accurately assess dentition for 1 resident (Residents #18) of 12 residents reviewed.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Other Specified Disorders of Teeth and Supporting Structure.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #18 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #18 had no tooth fragments and no broken natural teeth.</p> <p>Review of the RAI Manual dated 10/2024, revealed .The RAI process has multiple regulatory requirements . the assessment accurately reflects the resident's status .SECTION L: ORAL/DENTAL STATUS .intended to record any dental problems .No natural teeth or tooth fragment(s) .broken natural teeth .</p> <p>During an interview and observation on 3/25/2025 at 11:30 AM, Resident #18 stated he has had broken and missing teeth for years. Observation of Resident #18's oral cavity revealed multiple missing natural teeth, multiple broken natural teeth, and tooth fragments. Resident #18 stated he had no difficulty eating and no mouth pain.</p> <p>During an interview and observation in Resident #18's room, on 3/26/2025 at 2:52 PM, the MDS Coordinator stated he was responsible for the oral/dental assessment on the MDS assessment dated [DATE] for Resident #18. Observation revealed the resident had multiple missing and broken natural teeth as well as tooth fragments. The MDS Coordinator confirmed Resident #18's MDS assessment dated [DATE] was not accurate.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36003</p> <p>Based on facility policy review, medical record review, and interviews the facility failed to provide advanced notice of care plan conference meetings for 3 residents (Resident #1, #8, and #18) of 12 residents reviewed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed .The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .The IDT includes . The Attending Physician .A registered nurse [RN] who has responsibility for the resident .A nurse aid who has responsibility for the resident .The resident and the resident's legal representative (to the extent practicable); and .Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident .Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .Participate in the planning process .Participate in establishing the expected goals and outcomes of care .Participate in determining the type, amount, frequency and duration of care .The resident will be informed of his or her right to participate in his or her treatment .The care planning process will .Facilitate resident and/or representative involvement .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Anorexia, Major Depression, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Hypertension.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact.</p> <p>During an interview on 3/24/2025 at 11:15 AM, Resident #1 stated she had never been invited or participated in a care plan meeting.</p> <p>During an interview on 3/26/2025 at 9:10 AM, the RN MDS Coordinator stated the Social Services/Admissions Director was responsible for inviting residents and resident representatives to care plan meetings.</p> <p>During an interview on 3/26/2025 at 8:25 AM, the Social Services/Admissions Director stated she did not automatically notify or invite residents or resident representatives to quarterly care plan meetings. The Social Services/ Admissions Director stated .I understand I'm supposed to . and confirmed she had not invited Resident #1 nor the resident's representative to participate in quarterly care plan meetings.</p> <p>During an interview on 3/26/2025 at 8:51 AM, the Administrator confirmed his expectation was residents and resident representatives were to be invited to the quarterly care plan meetings.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/26/2025 at 9:51 AM, the Director of Nursing (DON) stated the Social Services/ Admissions Director worked with the MDS Coordinator and scheduled the care plan conference meetings.</p> <p>During an interview on 3/26/2025 at 1:38 PM, the RN MDS Coordinator stated he was unaware when the last care plan meeting was held for Resident #1 and stated the last documentation of a care plan meeting for the resident was 12/4/2023 and the resident had attended.</p> <p>41782</p> <p>Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Seizures, Chronic Pain, Delusional Disorders, Chronic Respiratory Failure, and Anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 7 on the BIMS assessment which indicated the resident was severely cognitively impaired.</p> <p>During a telephone interview on 3/24/2025 at 2:11 PM, Resident #8's responsible party reported she had never been invited to or participated in a care plan meeting.</p> <p>During an interview on 3/26/2025 at 8:57 AM, the Social Services/Admissions Director stated she was responsible to coordinate the 72-hour care plan meeting. Residents and family were invited to the care plan meeting in person or by phone. The previous receptionist was responsible to send out invites to family members and residents for quarterly care plan meetings. The Social Services/Admissions Director stated when the receptionist quit .about a year ago .I guess nobody was inviting residents and families to the meetings .I found that out today . The Social Services/Admissions Director stated she had not attended quarterly plan meetings and .I should be from what I understand this morning . It will be my job going forward to invite residents and families to the care plan meetings .I didn't know what I didn't know . The Social Services/Admissions Director stated she was made aware by the Administrator this morning that she would be responsible to start inviting residents and families to the quarterly care plan meetings. The Social Services/Admissions Director was unaware when the last care plan meeting was for Resident #8.</p> <p>During an interview on 3/26/2025 at 9:10 AM, the RN MDS Coordinator stated the Social Services/Admissions Director was responsible to invite residents and families to care plan meetings. The RN MDS Coordinator stated the facility had identified a concern .during the transition .within the last month . that residents and families were not being invited to the care plan meetings. Care plan meetings were attended by the RN MDS Coordinator, Social Services/Admissions Director, Dietary, Nursing representative, and therapy and activities representative if possible. The RN MDS Coordinator stated he was unaware where it was documented that residents or families were invited to attend the care plan meetings.</p> <p>During an interview on 3/26/2025 at 1:39 PM, the RN MDS Coordinator was unaware when the last care plan meeting was for Resident #8 and stated the last documentation of a care plan meeting for the resident was 12/4/2023 and Resident #8's responsible party attended.</p> <p>49786</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Other Specified Disorders of Teeth and Supporting Structure.</p> <p>Review of a significant change MDS assessment dated [DATE], revealed Resident #18 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the medical record for Resident #18 revealed no documentation the resident or resident representative were provided advanced notice of care plan conference meetings or evidence care plan conferences were held.</p> <p>During an interview on 3/25/2025 at 11:30 AM, Resident #18 stated he had never been notified verbally or in writing of quarterly care plan conference meetings.</p> <p>During an interview on 3/26/25 at 9:20 AM, the facility Social Services/Admissions Director stated she did not notify or invite Resident #18 or resident representative to participate in quarterly care plan conference meetings.</p> <p>During an interview on 3/26/2025 at 2:00 PM, the RN MDS coordinator stated he was unable to locate documentation to indicate the facility provided advanced notice to Resident #18 or resident representative of quarterly care plan conference meetings.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782</b></p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure oxygen tubing and humidification bottles were dated for 1 resident (Resident #8) of 4 residents reviewed for oxygen.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Oxygen Safety, revised 3/1/2022, revealed .The purpose of this procedure are to provide general information concerning oxygen safety and to promote safety precautions during oxygen administration .Steps in the Procedure .The tubing connected to the oxygen cylinder must be checked to assure that it is free of kinks. Tubing should be changed per manufactures guidance. Document initials and date of the tubing change on the tubing .The humidifying bottle should be used with all delivery systems unless contraindicated .Water bottle should be changed every 7 days. Document initials and date of the change on the water bottle .</p> <p>Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Chronic Respiratory Failure, Obstructive Sleep Apnea, and Hypertensive Heart and Chronic Kidney Disease.</p> <p>Review of a Physician's Order for Resident #8 dated 7/31/2024, revealed .Oxygen: Oxygen at 3 LPM [liters per minute] via NC [nasal cannula] .every shift .</p> <p>Review of the comprehensive care plan for Resident #8 dated 9/9/2024, revealed .resident has .Respiratory Failure .OXYGEN SETTINGS: O2 [oxygen] via nasal cannula as ordered .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was severely cognitively impaired. Further review revealed Resident #8 received oxygen therapy.</p> <p>During multiple observations on 3/24/2025 at 11:51 AM, 3/24/2025 at 12:31 PM, and 3/25/2025 at 8:46 AM, Resident #8 received humidified oxygen at 3 liters by nasal cannula. There was no date or staff initials on the oxygen tubing or humidification bottle.</p> <p>During an observation and interview in Resident #8's room on 3/25/2025 at 9:09 AM, with Licensed Practical Nurse (LPN) B, revealed the resident was on humidified oxygen at 3 liters by nasal cannula. LPN B confirmed the humidification bottle and oxygen tubing were not dated. LPN B stated the Central Supply Coordinator was responsible to change the tubing and humidification bottles and dates were to be on the bottle with the date they were changed. LPN B confirmed she was not aware how long the tubing or bottle had been in use because it was not dated.</p> <p>During an interview on 3/25/2025 at 3:25 PM, the Central Supply Coordinator stated she was responsible to change the oxygen tubing and humidification bottles for residents receiving oxygen weekly. The Central Supply Coordinator confirmed the tubing and humidification bottles were to be labeled with the date they were changed. The Central Supply Coordinator stated the date of the change was not documented anywhere except on the tubing and humidification bottle.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/25/2025 at 3:45 PM, the Registered Nurse (RN) MDS Coordinator confirmed oxygen tubing and humidification bottles were to be changed every 7 days and as needed. The RN MDS Coordinator stated the tubing and humidification bottles were to be dated when changed and the Central Supply Coordinator was responsible to change them. The RN MDS Coordinator stated he was unaware of anywhere the tubing and humidification bottle date would be documented other than on the tubing and bottles. The RN MDS Coordinator stated Resident #8 had no respiratory infections or respiratory problems recently.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51734</p> <p>Based on facility policy review, observations, and interviews, the facility failed to ensure the kitchen cooking equipment was maintained in a sanitary condition and failed to discard an expired cold food item in 1 of 1 walk-in refrigerator which had the potential to affect 29 of 29 residents.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Policy Statement, revealed .the food service area shall be maintained in a clean and sanitary manner .all equipment .shall be washed to remove or completely loosen soils by using manual .means necessary and sanitized .</p> <p>During an observation and interview of the cooking area on [DATE] at 12:15 PM, with the Dietary Manager (DM) revealed the griddle cook top had brownish-black food debris present with a grease-like residue impacted to the inner parameter of the griddle. Further observation revealed a grease-like residue with various brownish-black food particles present on the outer left panel of the griddle which extended down to the gas range. The DM stated the griddle cook top and the cooking surfaces were .wiped down . after each use and deep cleaned each night.</p> <p>During an observation and interview of the walk-in refrigerator area on [DATE] at 12:27 PM, with the DM, revealed one 32-ounce (oz) container of lime juice with an open date of ,d+[DATE] (year unknown) and no expiration date labeled on the product. The DM stated opened food items stored in the refrigerator should be discarded within 7 days of opening. The DM confirmed the expired lime juice was available for resident use and should be discarded.</p> <p>During an observation and interview of the cooking area on [DATE] at 9:55 AM, with the DM, revealed the griddle cook top had brownish-black food debris present with a grease-like residue impacted to the inner parameter of the griddle. Continued observation revealed a grease-like residue present with various brownish-black food particles to the outer left panel of the griddle which extended down to the gas range. The DM confirmed the griddle cook top and the left panel of the griddle was not maintained in a sanitary condition and needed to be cleaned.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782</b></p> <p>Based on medical record review and interview the facility failed to ensure the medical record was complete and accurate related to Advance Directives for 1 resident (Resident #432) of 16 residents reviewed for Advance Directives.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #432 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, History of Falling, and Need for Assistance with Personal Care.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #432 scored a 15 on the Brief Interview for Mental Status assessment which indicated the resident was cognitively intact.</p> <p>Review of the Baseline Care Plan for Resident #432 dated 3/7/2025 revealed .CODE STATUS .Do Not Resuscitate .Living will/advanced directive will be honored .Physician's order of code status .Honor resident wishes .</p> <p>Review of the ADMISSION AGREEMENT dated 3/7/2025, revealed .Attachment C - Advance Directive Acknowledgement I have executed an Advance Directive . Continued review revealed .Attachment D - Advance Directives . was a chart that was to be completed to show if the resident had .Living Will; Declaration or Directive to Physicians .Power of Attorney (Business and Financial Management) .Durable Power of Attorney for Healthcare .Guardian .Do Not Resuscitate .Other (specify) . and .Advance Directive(s) received and placed in Resident's medical record .Center representative told Advance Directive (s) exists, but resident has not produced copies . was blank and had not been completed. Continued review revealed there was no signature from facility staff or the resident/resident representative for the section that stated . The Resident acknowledges that it is the Resident's responsibility to provide the Center with copies of the Resident's advance directives for incorporation into the Resident's medical record .</p> <p>During an interview on 3/25/2025 at 2:19 PM, the Administrator stated there were no Advance Directives in Resident #432's medical record.</p> <p>During an interview on 3/25/2025 at 2:48 PM, Resident #432 stated she had a Durable Power of Attorney and Living Will. Resident #432 was unable to recall if the facility had requested a copy of her advance directives on admission.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/2025 at 8:37 AM, the Social Services/Admissions Director stated she was responsible to complete the Admission Agreement with the resident or resident representative on admission including the Advance Directive sections. Resident #432's daughter completed the Admission Agreement with the Social Services/Admissions Director on admission and reported she believed the resident had medical and financial Power of Attorney. The Social Services/Admissions Director asked Resident #432's daughter to bring in the form and take it to the Business Office to be placed in the medical record. The Social Services/Admissions Director stated she spoke with Resident #432 on admission but did not ask the resident specifics about her Advance Directives. The Social Services/Admissions Director was unaware if Resident #432's daughter provided a copy of the Advance Directive and stated she was unaware who was responsible to follow up on ensuring Advance Directives were brought in for the medical record. This surveyor reviewed the Admission Agreement sections related to Advance Directives with the Social Services/Admissions Director and the Social Services/Admissions Director confirmed the section to indicate what Advance Directives the resident had was blank and incomplete.</p> <p>During an interview on 3/26/2025 at 9:27 AM, the Administrator confirmed the Social Services/Admissions Director was responsible to complete the Admission Agreement including the Advance Directive sections. The Administrator confirmed it was his expectation the forms were filled out completely and Resident #432's Advance Directive section of the Admission Agreement was not complete.</p>		