STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF EUPORA	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)
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.** Based on staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan for respiratory care related to storage of respiratory equipment, for two (2) of seven (7) resident care plans reviewed for Respiratory Care; Resident #27 and Resident #72. Findings include: Review of the facility's Care Plans policy, with an effective date of June 2017, revealed: Care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change. Resident #27 Record review of Resident #27's care plan, revealed a focused problem for Alteration in Respiratory Status. Interventions included to store nebulizer in plastic bag when not in use. During an observation, on 03/02/2020 at 11:32 AM, Resident #27's nebulizer mask was observed unbagged, lying on top of the nebulizer machine. There was no bag or other protective cover seen in the resident ' s room. An observation, on [DATE]20 at 10:49 AM, revealed Resident #27's nebulizer mask was lying on top of her nebulizer machine and not in a bag. On 03/04/2020 at 10:05 AM, during an observation, Resident #27's nebulizer mask remained on top of the nebulizer machine and not in a protective cover. During an observation and interview, on 03/04/2020 at 11:48 AM, with Registered Nurse (RN) #1, she confirmed Resident #27's nebulizer mask was lying on top of the nebulizer machine uncovered. During an observation of Resident #27's care plan, with the Director of Nursing (DON), she confirmed Resident #27 had a care plan with an intervention to store the nebulizer mask in a plastic bag when not in use. An interview, on 03/04/2020 at 2:30 PM, with the DON, confirmed Resident #27's care plan was not followed. Resident #72 Record review of Resident #72's care plan revealed a problem which focused on Alteration in Respiratory Status. Interventions revealed to store nebulizer in plastic bag when not in use. An observation, on 03/02/2020 at 11:37 AM, revealed, Resident #72's [MED]gen (O2) cannula and tubing were on the floor behind her wheelchair. The nebulizer mask was not stored in a container to prevent contamination. During an observation, on [DATE]20 3:24 PM, Resident #72's [MED]gen cannula was noted to be draped over the back of her wheelchair, with the cannula lying on her wheelchair seat cushion. Resident #72's nebulizer machine and nebulizer mask was sitting on the overbed table, and not in a bag. On 03/04/2020 at 11:48 AM, during an observation with RN #1 and LPN #2, revealed, Resident #72's [MED]gen tubing was draped over the back of her wheelchair, and her handheld nebulizer was on her nebulizer machine uncovered. During an interview, on 03/04/2020 at 11:52 AM, RN #1 revealed she knew [MED]gen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. An interview, on 03/04/2020 at 11:53 AM, with LPN #2, confirmed that all respiratory equipment should be in bags. During an interview, on 03/04/2020 at 2:30 PM, the DON confirmed Resident #72's care plan was not followed.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** Based on observation, resident interview, staff interview, and policy review, the facility failed to store respiratory equipment in a manner to prevent contamination, for six (6) of seven (7) residents reviewed for respiratory care; Resident #3, Resident #27, Resident #53, Resident #72, Resident #87 and Resident #103. Findings include: Review of the facility's Policies and Practices-Infection Control policy, dated, November 1, 2017, revealed, This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Resident #3 During an observation, on 03/02/2020 at 12:24 PM, Resident #3's [MED]gen tubing revealed, the tubing was not dated or labeled. Resident #3's [MED]gen tubing was draped across his [MED]gen concentrator and dangling. There was no evidence of a protective covering for the [MED]gen tubing in the room. On [DATE]20 at 9:20 AM, an observation of Resident #3's [MED]gen tubing, revealed it was draped across his [MED]gen concentrator and continued to be undated and labeled. Resident #3's [MED]gen tubing was not in a protective covering. On 03/04/2020 at 11:10 AM, Resident #3's [MED]gen tubing was noted to be laying across his [MED]gen concentrator and not in a bag. During an interview, on 03/04/2020 at 11:17 AM, Licensed Practical Nurse (LPN) #1 stated the night shift nurse is responsible for changing out the water, tubing, labeling items and placing them in a plastic bag weekly. LPN #1 confirmed Resident #3's tubing was not dated or in a plastic bag. She stated the [MED]gen tubing should be placed in a bag for infection control purposes, and that you wouldn't want the tubing touching any contaminated surfaces. Resident #53 On 03/02/20 at 2:54 PM, during an observation, Resident #53's [MED]gen tubing was noted to be wrapped around her bed rail frame and not in a protective covering. On [DATE] at 3:54 PM, an observation of Resident #53's [MED]gen tubing, revealed it was wrapped around the bed rail frame and uncovered. Resident #103 During an interview and observation, on 03/02/2020 at 10:33 AM, Resident #103's [MED]gen tubing revealed, the tubing was hooked through the water pitcher handle. Resident #103 stated that she had put it there, so it would stay off the floor. Resident #103 stated, at times, she draped it over her [MED]gen concentrator. On [DATE]20 at 9:00 AM, during an observation, Resident #103's [MED]gen tubing was observed lying across the [MED]gen concentrator and was not in a protective cover. During an interview, on 03/04/2020 at 11:17 AM, LPN #1 stated the night shift nurse was responsible for changing out the water, tubing, labeling items, and placing them in a plastic bag weekly. LPN #1 stated the [MED]gen tubing should be placed in a bag for infection control, and that you wouldn't want the tubing touching any contaminated surfaces. On 03/04/2020 at 12:07 PM, an interview with the Director of Nursing (DON), revealed, she stated the facility does not have a policy specific to [MED]gen tubing and proper storage, but that all tubing and humidified bottles of water are changed weekly on the 11 AM to 7 AM shift and should be dated and labeled. The DON stated the tubing should be stored in a plastic bag for infection control purposes and for safety. Resident #27 An observation, on 03/02/2020 at 11:32 AM, revealed Resident #27's nebulizer mask was not bagged, and lying on top of the nebulizer machine. No bag or other protective cover was observed in room. During an observation, on [DATE]20 at 10:49 AM, Resident #27's nebulizer mask was lying on top of her nebulizer machine and not stored in a bag. An observation, on 03/04/2020 at 10:05 AM, revealed, Resident #27's nebulizer mask remained on top of the nebulizer machine and not in a protective cover. During an observation and interview, on 03/04/2020 at 11:48 AM, with Registered Nurse (RN) #1, she confirmed Resident #27's nebulizer mask was lying on top of the nebulizer machine uncovered. RN #1 revealed, she knew [MED]gen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. On 03/04/2020 at 11:53 AM, during an interview, LPN #2 confirmed that all respiratory equipment should be in bags. Resident #72 An observation, on 03/02/2020 at 11:37 AM, revealed, Resident #72's [MED]gen (O2) cannula and tubing was on the floor behind her wheelchair. Resident #72's nebulizer mask was not stored in a container to prevent contamination. During an observation, on [DATE]20 3:24 PM, Resident #72's

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF EUPORA	**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)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) [MED]gen cannula was draped over the back of her wheelchair, with the cannula lying on her wheelchair seat cushion. Resident #72's nebulizer machine and nebulizer mask was sitting on the overbed table and was not in a bag. On 03/04/2020 at 11:48 PM, during an observation, with RN #1 and LPN #2, Resident #72's [MED]gen tubing was noted to be draped over the back of her wheelchair, and her handheld nebulizer was on her nebulizer machine uncovered. During an interview, on 03/04/2020 at 11:52 AM, RN #1 revealed she knew [MED]gen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. During an interview, on 03/04/2020 at 11:53 AM, LPN #2 confirmed that all respiratory equipment should be in bags. Resident #87 During an observation of Resident #87's room, on 03/02/2020 at 10:40 AM, the resident ' s [MED]gen cannula and tubing were lying on the bed without being in a storage bag. Resident #87 was not present in the room. During an interview and observation, on 03/02/2020 at 12:33 PM, Resident #87, stated that he used [MED]gen most of the time when he was in his room, but does not use it when he leaves his room. Resident #87 stated when he leaves the room, he takes his [MED]gen off, and places the cannula on the bed. Resident #87 stated he had storage bags in the past, but not lately. Resident #87's [MED]gen cannula and tubing were observed on the bed, until the resident picked it up to put on. An observation, on [DATE]20 at 10:00 AM, revealed Resident #87's [MED]gen cannula was on bed and no storage bag available. Resident #87 was not in the room. During an observation on, 03/04/2020 at 8:33 AM, Resident #87 was in the room wearing [MED]gen. There was no bag for storage at noted at the resident's bedside. During an observation and interview with LPN #2, on 03/04/2020 at 11:30 AM, revealed, Resident #87's [MED]gen tubing was lying on the bed and no storage bag was noted. Resident #87 was not present in the room. LPN #2 stated the [MED]gen tubing should be stored in a plastic bag to keep it clean when not in use, and staff should date these bags. LPN #2 confirmed a storage bag was not in the resident's room for use.