STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255139	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Batesville	154 Woodland Road Batesville, MS 38606

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to promote dignity for two (2) of 35 residents in the sample. (Resident's #44 and #106) Findings include: Review of the facility policy titled, Resident Rights & Quality of Life, with an effective date of March 13, 2020, revealed, Policy: It is the policy of proper name that all patients have the right to a dignified existence, self-determination, and communication with access to services inside and outside the facility. Resident #44 An observation on 6/9/25 at 10:35 AM revealed Resident #44 was observed licking chocolate pudding from a small Styrofoam bowl. Chocolate pudding was observed on the resident's nose, around the mouth, and drops of pudding on his shirt, top sheet, and blanket. Resident #44 stated he was trying to eat the pudding but was not given a spoon. No spoon was observed in the resident's room. An observation and interview with Certified Nurse Assistant (CNA) #5 on 6/9/25 at 10:38 AM confirmed that Resident #44 did not have a spoon to eat his pudding, and confirmed the resident had chocolate pudding on his face and bed linens from trying to eat the pudding with no utensils. CNA #5 revealed this is a dignity concern because the resident attempted to lick the pudding out of the bowl, resulting in him getting pudding on his face, clothing, and bed linens. An interview with the Infection Preventionist on 6/10/25 at 1:10 PM confirmed it would be a dignity concern and could be embarrassing to have pudding on his face and stated staff should have provided the resident with a spoon. An interview with the Director of Nursing (DON) on 6/10/25 at 1:45 PM confirmed it was a dignity concern for Resident #44 to have to lick pudding out of a cup, resulting in the resident getting pudding on his face and linens. Record review of the admission Record revealed that Resident #44 was admitted to the facility on [DATE] with a diagnosis of nontraumatic intracranial hemorrhage. Record review of Resident #44's Section C of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 8, (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating the resident was moderately cognitively impaired. Resident #106 An observation of Resident #106's room on 6/9/25 at 10:10 AM revealed a Wound VAC (Vacuum-Assisted Closure) on the bedside nightstand next to the resident's bed, half full of dark, thick serous drainage, with a foul odor noted. The drainage container was visible from the doorway of the room and was not in use. Resident was observed sleeping. During an observation and interview with Licensed Practical Nurse (LPN) #2 on 6/9/25 at 11:41 AM, she confirmed the wound VAC was sitting on Resident #106's nightstand and confirmed it was not in use. She confirmed the drainage container was half full of old, thick, drying, putrid serous drainage. She also confirmed this was a dignity concern to have the drainage visible for everyone to see. An interview with Infection Preventionist on 6/10/25 at 12:57 PM confirmed that when Resident #106's wound VAC canister containing the old serous drainage was a dignity concern related to the drainage being visible to anyone entering the room. An interview with the DON on 6/10/25 at 1:50 PM revealed she saw the serous drainage left in Resident #106's room in the wound VAC, stating, It was awful. She stated the wound VAC was used a day and then changed because the resident kept taking it off. She stated that when the order was discontinued, the wound VAC should have been removed from the room and cleaned, and the vacutainer containing the serous drainage should have been disposed of in the biohazard room in a biohazard bag. She then revealed concerns about leaving the wound vacuum in the room for days after it was discontinued, as it is a dignity concern because the drainage was not covered. Record review of the admission Record revealed that Resident #106 was admitted to the facility on [DATE] with diagnoses of end stage renal disease and an unspecified open wound to the lower leg. Record review of Resident #106's Section C of the MDS with an ARD of 5/29/25 revealed a BIMS score of 15, indicating the resident was cognitively intact.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure a resident was free from neglect as evidenced by not ensuring the availability of a functioning total mechanical lift or alternative transfer method for one (1) of 36 residents that required the use of a total lift. (Resident #96) Findings Include: Review of the facility policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, effective January 2019, revealed under Purpose .To prohibit and prevent abuse, neglect .Neglect: Failure of the center, its team members .to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . An interview on 06/09/25 at 1:19 PM with Resident #96 revealed that one night the previous week, she had to sit in her wheelchair from afternoon until approximately 3:00 AM because all of the lifts were not charged. She stated that eventually, an ambulance service was called, and they lifted her manually and put her back to bed. The resident reported she had peed and pooped on herself and experienced pain requiring pain medication. She stated, This is just ridiculous that all of their lifts were not working. I don't even like to get out of bed, much less stay up that long. Record review of Resident #96's lift/transfer assessment dated [DATE] documented that Resident #96 required a total mechanical lift for all transfers. Record review of Resident #96's Medication Administration Record (MAR) for the month of 6/2025 revealed the resident had one incident of reported pain on a 10/10 scale and received a PRN (as needed) pain medication and that was on 6/4/2025 at 7:38 PM. An interview on 06/10/25 at 1:24 PM with CNA #2 confirmed the total lift batteries were not working on the night of the incident with Resident #96, which was 6/4/25. She stated that some batteries had been intermittently failing and that the Administrator had been informed prior to the incident. An interview on 06/10/25 at 1:27 PM with the Administrator and Director of Nursing (DON) confirmed that no charged total lift batteries were available during parts of the 3 PM-11 PM and 11 PM-7 AM shift on Wednesday 6/4/25. The Administrator stated she had been informed on Monday 6/2/25 about battery charging issues and ordered replacements, which did not arrive until Friday. She acknowledged being notified around 8 PM on 6/4/25 that the lifts were nonfunctional, but they continued to try and get them to charge. She admitted that she eventually instructed staff to call the ambulance service and was notified that the resident was returned to bed at approximately 11:51 PM. Both the Administrator and DON agreed the resident should not have had to sit up that long in her wheelchair. A phone interview on 06/10/25 at 1:38 PM with Licensed Practical Nurse (LPN) #1 confirmed she worked the 7 PM-7 AM shift on C Hall 6/4/25 and that none of the batteries were charged at the start of her shift. She stated only one battery eventually charged and was used to put one resident back to bed, but it was depleted by the time A Hall needed it. She confirmed that EMS was called and arrived around 11 PM to assist with returning Resident #96 to bed. She acknowledged no manual backup lift was available and that being without a total lift for so long bothered her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview on 06/10/25 at 2:00 PM with the DON confirmed Resident #96 was totally incontinent and left in her wheelchair from approximately 2 PM until around 11 PM on 6/4/25. She stated no skin or body assessment was completed after the resident was returned to bed but acknowledged that one should have been done. She confirmed the facility did not have an alternative back up lift to replace the non-functioning battery-operated lifts. An interview on 06/10/25 at 2:30 PM with the Wound Nurse confirmed she had not been made aware of the incident and agreed a post-incident assessment should have occurred. A phone interview on 6/11/25 at 10:38 AM with CNA #3, who worked 10:30 PM-6:30 AM on 6/4/25, revealed that Resident #96 was returned to bed around 11 PM. She reported the resident was saturated with urine and had a bowel movement extending from her back to her perineal area. She stated no nurse assessed the resident's skin and expressed frustration about the lack of working equipment. An interview on 6/11/25 at 10:45 AM with the DON confirmed that Resident #96 had no documentation of incontinent care for the time she was in the wheelchair on 6/4/25, which was approximately 2 PM-11 PM. She was not aware of the resident's state of incontinence when she was finally transferred back to bed at approximately 11 PM, reported a pain score of 10/10 or the PRN pain medication given that evening and stated, That's terrible. An interview on 6/11/25 at 11:20 AM with the Registered Nurse (RN)/Lift Champion revealed she had been notified on 5/30/25 about the charging issues with the total lift batteries and had reported the issue to the Administrator, who then ordered new batteries. She confirmed that none of the lifts were functional on the night of 6/4/25 and stated, It's terrible that the resident was left that long. She stated that her job as the lift champion was to make sure the slings were not broken and admitted that she made random rounds to check the lift batteries and there were no issues on the day of 6/4/25 that she was aware of. A phone interview on 6/11/25 at 11:34 AM with CNA #4 confirmed that Resident #96 had been gotten up by therapy around 2 PM after receiving a bed bath earlier in the day. She admitted the resident was not toileted or put back to bed before the end of her shift at 3 PM. An interview on 6/11/25 at 11:40 AM with the Certified Occupational Therapy Assistant (COTA) confirmed therapy got Resident #96 up around 1-1:30 PM on 6/4/25. She was not soiled at the time, and therapy concluded around 2:30 PM. An interview on 6/11/25 at 12:45 PM with the Administrator confirmed she was unaware the resident experienced a pain score of 10/10 or that she was saturated with urine and feces on the night of 6/4/25. An observation and interview on 6/11/25 at 2:09 PM with Resident #96 and the Wound Care Nurse revealed no skin breakdown or complaints during a sacral/perineal skin assessment. Record review of Resident #96's admission Record revealed the facility admitted the resident on 9/12/24 with diagnoses including Malignant Neoplasm of the Center Portion of the Left Breast, Joint Stiffness and Pain. Record review of Resident #96's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14 indicating the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident was cognitively intact and in Section GG that the resident was dependent for transfers with 2-person assistance and toileting.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review and review of the facility's dialysis contract, the facility failed to assess and document the presence of a bruit and thrill at the dialysis access site as part of routine monitoring as ordered for one (1) of four (4) dialysis residents reviewed: Resident #86 Findings include: Review of the typed statement on facility letterhead dated 6/12/25 revealed that it is the practice of (the facility) to follow contracts with their partnered Dialysis center and provide care in accordance with CMS guidance. Review of the facility's contract Long Term Care Facility Outpatient Dialysis Services Coordination Agreement with the off-site dialysis provider (effective 1/18/17) revealed, .Long Term Care Facility participates as a residential and health care provider of services .and promotes its End-Stage Renal Disease (ESRD) Resident's rights to obtain .benefits and services appropriate to their needs . Record review of Order Summary Report for active orders as of 6/1/25, revealed, .Hemo-Dialysis: Auscultation/Palpitation of shunt site for Bruit and Thrill every (Q) shift with order date 11/14/2024. Review of Dialysis Communication Records for June revealed assessment of site for bruit/thrill on 6/3/25, 6/5/25. 6/7/25, and 6/10/25. Record review of the Medication Administration Record (MAR) for 6/1/25 - 6/10/25 revealed the order for assessment of shunt site for bruit and/or thrill of Resident #86's shunt in his left arm was not on the MAR. During an interview on 6/10/25 at 2:35 PM with the Director of Nursing (DON) regarding Resident #86, it was confirmed the order was not listed on the MAR/TAR (Treatment Administration Record) and the only documentation for auscultation/palpitation of the shunt site for bruit and thrill was on the dialysis communication forms. She stated that the purpose of checking the shunt site is to ensure that the shunt is functioning properly and has not malfunctioned. She further verbalized that should the shunt stop working, the resident would not be able to receive dialysis and would possibly have to have his shunt replaced. Record review of the admission Record revealed that Resident #86 was admitted to the facility on [DATE] with a diagnoses End-stage Renal Disease (ESRD). Record review of Resident #86's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, staff interview, and facility policy review, the facility failed to ensure medications on the treatment cart were locked and secured for one (1) of five (5) medication /treatment carts observed. Findings include: Review of the facility's policy titled, (Proper Name) Medication Storage, revised 4/23, states, .it is the responsibility of the facility to keep the medication cart locked and secure at all times when not in use . During an observation on 6/9/25 at 11:29 AM, of the treatment cart on Hall A, revealed it was unlocked and unattended, with keys placed on top of the cart. Wound Nurse exited a resident's room, and the room door had been closed. During an interview with the Wound Nurse she stated, A resident could have walked by, opened up the cart, and ingested something they should not have and confirmed, I should not have left it open, and I should not have left my keys on my cart. An interview was conducted on 6/9/25 at 2:31 PM with the Director of Nursing (DON), who confirmed that the nurse should never leave the cart unlocked and should not have left her keys on top of the cart.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review and facility policy review, the facility failed to ensure a timely evaluation by therapy services after a referral was made for one (1) of 35 sampled residents. Resident #22. Findings include: Record review of facility policy titled, Resident Screening Guidelines updated 3/14/18 revealed, screenings be completed by (Formal Name) employees . upon referral by the medical and/or nursing department of a facility . Record review of Interdisciplinary Rehabilitation Screening Form with effective date 5/23/2025, revealed, Nursing referral due to onset of decreased strength, decreased endurance, and functional decline. Occupational Therapy (OT) evaluation indicated. An interview on 6/11/25 at 1:45 PM with the Director of Nursing (DON) confirmed, nursing did make a referral on 5/23/25 for an OT evaluation, however there was no documentation of an evaluation by OT. She stated, you will have to check with therapy about that. An interview on 6/11/25 at 3:11 PM with the Director of Therapy confirmed the nursing referral date 5/23/25 was not processed timely. She stated, I'm not sure how we missed that one. She further verbalized that the person that performed their OT evaluations was out on medical leave, however they did have someone available via telehealth for evaluations and that she was evaluating Resident # 22 right now (today). When asked could this evaluation been performed via telehealth when nursing made the referral on 5/23/25, she confirmed, yes. She revealed referrals for evaluations are expected to be evaluated between 24-48 hours after they are received. She further stated that Resident # 22 was at increased risk for further decline and even increased risk for hospitalization due to the delay in the evaluation. Record review of the admission Record revealed Resident #22 was admitted on [DATE] with diagnoses including Alzheimer's Disease. Record review of Resident #22's Section C of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident had moderate cognitive impairment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and facility policy review, the facility failed to maintain proper infection control practices for one (1) of 35 sampled residents. (Resident #106) Findings Include Review of the facility policy titled, Policies and Practices-Infection Control, effective date November 1, 2017, revealed: Policy Statement: This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help manage the transmission of diseases . On 6/9/25 at 10:10 AM an observation of Resident #106's room revealed a Wound VAC (Vacuum-Assisted Closure) on the bedside nightstand next to the resident's bed, half full of dark, thick serous drainage, with a foul odor noted. The drainage container was visible from the doorway of the room and was not in use. On 6/9/25 at 11:41 AM during an observation and interview with Licensed Practical Nurse (LPN) #2 , she confirmed the wound VAC was sitting on Resident #106's nightstand and that it was not in use. She also confirmed the drainage container was half full of old, thick, drying putrid serous drainage and stated this was an infection control concern due to the resident being medically compromised and at increased risk of infection. Review of the May 2025 Treatment Record for Resident #106 revealed, wound care to right lower extremity to be done every three days as needed for soilage and dislodgement. Cleanse area with wound cleanser, pat dry, protect peri wound by applying no sting barrier films. Picture frame wound with transparent film dressing. Apply black foam to wound bed only, cover with transparent dressing. Cut quarter size hole in dressing, connect to port. Set at 125 mmHg (millimeters of mercury) one time a day every Wednesday and Friday related to open wound with an order date of 5/28/25 and a discontinue date of 5/30/25. On 6/10/25 at 12:57 PM an interview with the Infection Preventionist confirmed that the wound VAC device and the canister containing the biohazard waste should have been immediately removed from the room and the waste properly disposed of in the biohazard room. The Infection Preventionist expressed concerns about leaving the wound vacutainer with old serous drainage in it, as it poses an increased risk of spreading infection. On 6/10/25 at 1:50 PM an interview with the Director of Nursing (DON) confirmed she saw the serous drainage left in Resident #106's room in the wound VAC, stating, It was awful. She stated that it was only used one day and should have been removed when it was discontinued. She further revealed concerns that leaving the wound VAC in the room for days after it was discontinued could increase the risk of spreading infection. Review of the admission Record revealed that Resident #106 was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease and an unspecified open wound to the lower leg. Record review of Resident #106's Section C of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating the resident was cognitively intact.