

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Diversicare of Quitman		STREET ADDRESS, CITY, STATE, ZIP CODE 191 Highway 511 East Quitman, MS 39355	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to provide supervision to prevent a resident-on-resident altercation when Resident #61 wandered into another resident's room, which resulted in Resident #61 receiving a hematoma to her forehead and an emergency department (ED) visit for one (1) of 22 sampled residents, Resident #61.</p> <p>Findings included:</p> <p>A record review of the facility's Investigation Template, dated 11/11/2024, revealed that at approximately 6:20 AM on 11/11/2024, a floor tech summoned help to Resident #91's room. Staff found water on the floor, a water pitcher spilled, and Resident #91 sitting on her bed holding her purse. Resident #91 stated she thought a man was trying to take her belongings and said she protected herself. Resident #61 was removed from the room and was noted to have a hematoma on the left side of her forehead and redness on the left side of her face. Resident #61 was assisted to her room and transported to a local hospital's ED.</p> <p>A record review of the local hospital's ED report, dated 11/11/2024, revealed that Resident #61 arrived at the ED at 4:51 PM and was discharged at 5:35 PM .History: Head Injury: Another resident at nursing home hit pt (patient) on head (upper eyebrow) .Review of Systems . Positive for wound (hematoma to left forehead) .Final diagnoses .Contusion of forehead, injury of head .</p> <p>On 12/15/2024 at 10:12 AM, during an observation of Resident #91's room where the altercation with Resident #61 occurred, there was a stop sign with a Velcro closure across the width of the door. During an interview with Resident #69 (Resident #91's roommate) she reported that she did not see the altercation between her roommate and Resident #61 because she was asleep. She reported that Resident #61 occasionally entered their room but stated the incidents decreased after the stop sign was installed.</p> <p>On 12/16/2024 from 9:30 AM to 10:00 AM, during an observation, Resident #61 was observed wandering throughout the facility, sleeping in hallways where she does not reside. Staff redirected her to her hallway after approximately 30 minutes.</p> <p>On 12/18/2024 at 9:50 AM, during an interview, the Administrator stated she was informed of the incident that occurred on 11/11/2024 by the DON and it was discussed during the facility's daily Stand-Up meeting. Staff determined interventions such as implementing stop signs and monitoring Resident #61 upon waking should be added.</p> <p>On 12/18/2024 at 11:13 AM, during an interview, the Floor Tech stated that on 11/11/2024 at 6:20</p> <p>(continued on next page)</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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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>AM, he heard a commotion from Resident #91's room. Upon entering, he saw Resident #91 on her bed and Resident #61 in her wheelchair. He reported that a Training Center Account Manager (TCAM) assisted with removing Resident #61 and cleaning the water on the floor.</p> <p>On 12/18/2024 at 11:16 AM, during an interview, the TCAM stated she entered D-Hall at approximately 6:20 AM and saw the Floor Tech cleaning water. She stated she removed Resident #61 from Resident #91's room and heard Resident #91 say, Get out, get out, you don't belong in here.</p> <p>On 12/18/2024 at 11:40 AM, during an interview, Registered Nurse (RN) #3 stated she was informed of the incident during her medication pass. She reported the incident to the DON and Nurse Practitioner, completed an incident report, and performed neurological checks.</p> <p>On 12/18/2024 at 11:50 AM, during an interview, the DON stated she was informed of the incident before arriving at the facility. She ensured residents were separated, reported the incident to the State Agency, and started an investigation. She confirmed the implementation of stop signs on doors of residents who complained about Resident #61 entering their rooms.</p> <p>A record review of the facility's admission Record revealed the facility admitted Resident #61 on 10/30/2020 with diagnoses including Unspecified Dementia.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/2024 revealed staff assessed Resident #61's cognitive status as severely impaired.</p>		