STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445249	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Martin	158 MT Pelia Rd Martin, TN 38237

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to educate and provide written information to residents regarding a right to formulate an advanced directive for 4 of 24 residents (Residents #24, #36, #75, and #239) reviewed. The findings include: 1.Review of the facility's policy titled, Advance Directives, dated 11/1/2016, revealed .[Named facility] recognizes the right of each resident to issue Advance Directives regarding his or her health care .and a right to formulate, at the individual's option, an Advance Directive .will provide Residents with information regarding Advance Directives at admission .If a Resident is incapacitated .unable to receive information about Advanced Directives or articulate whether he/she has an Advance Directive .will provide information regarding Advance Directives to the Resident's family or Resident Representative .will document in the Resident's medical record whether or not the Resident has executed an Advance Directive . 2.a. Review of the medical records revealed Resident #24 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Diabetes, and Chronic Obstructive Pulmonary Disease. Review of the annual MDS assessment dated [DATE], revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive. b. Review of the medical records revealed Resident #36 was admitted to the facility on [DATE], with diagnoses of including Diabetes, Heart Failure, and Kidney Failure. Review of the quarterly MDS assessment dated [DATE], revealed Resident #36 had BIMS score of 15, which indicated intact cognition. The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] with diagnoses including Dementia, Alzheimer's, and Bipolar Disorder. Review of the significant change in status MDS assessment dated [DATE], revealed Resident #75 BIMS score of 13, which indicated intact cognition. The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive. d. Review of the medical record revealed Resident #239 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Kidney Failure, and Heart Disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #239 had a BIMS score of 15, which indicates intact cognition. The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive. During an interview on 4/2/2025 at 10:58 AM, the Administrator confirmed that she had provided everything she had related to advanced directives. The facility was unable to provide documentation that the residents were educated and provided written information regarding their right to formulate an advanced directive.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure residents were free of physical restraints for 1 of 1 (Resident #29) sampled residents reviewed for restraints. The findings include: 1. Review of the facility policy titled, Physical Restraint Guideline, dated 6/2017, revealed .For each patient/resident to maintain his or her highest practical health or well being in an environment that prohibits the use of restraints .and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints .Upon determination a patient/resident presents with medical symptoms that may require a restraint, they are evaluated .The Care Plan .is reviewed .revised to include restraint use. 2. Review of the medical record review revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Repeated Falls, Dementia, and Anxiety. Review of an Order Summary Report dated 8/19/2022, revealed .self release alarm seat belt to wheelchair every day and night shift for preventative . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #29 was rarely/never understood and severely cognitively impaired. She is dependent on staff for all activities of daily living. Resident #29 is not assessed for a trunk restraint. Review of the Care Plan dated 4/1/2025, revealed Resident #29 was at risk for falls, with an intervention in place dated 11/30/2022, with education regarding self release seatbelt. Observation on 3/31/2025 at 10:58 AM and 2:58 PM, 4/1/2025 at 7:54 AM and 1:37 PM, and 4/2/2025 at 7:49 AM, revealed Resident #29 was sitting up in her wheelchair with a self release waist belt intact. Observation and interview on 4/2/2025 at 9:02 AM, the DON and Unit Manager took Resident #29 to her room. Resident #29 was asked and encouraged to release her waist belt several times, she was pleasantly confused and unable to release the belt. The DON at this time confirmed Resident #29 has a restraint on and she should be monitored and assessed for a restraint. DON stated, I will call her daughter and probably remove it. During an interview on 4/5/2025 at 8:57 AM, the Director of Nursing (DON) was asked if Resident #29's self release belt was a restraint. The DON stated, No, because she can take it off depending on her mood .her daughter insists she has this on due to previous falls .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on the facility's Clinical Skills Fair Guide, observation, and interview, the facility failed to use proper supplies when 1 of 5 nurses (Licensed Practical Nurse (LPN) A) administered medication from a flex pen during medication administration. The findings include: 1. Review of the [Named Facility] Clinical Skills Fair Guide, page 32 FLEX PEN [a pre-filled insulin delivery device] COMPETENCY AUDIT AND ADMINISTRATION GUIDE . revealed .REQUIRED MATERIALS . FlexPen .FLexPen needles .Removes the cover from the syringe .Opens new needle .screws the needle onto the FlexPen .Dials the number of units needed to inject .1 click=[equals] 1 unit of insulin .injects insulin by pressing the push button all the way in .Leaves the needle under the skin for at least 10 second after injecting insulin .Keep the button fully depressed until withdrawing the needle .Removes the needle from the pen . 2. An observation and interview during medication administration on 4/1/2025 at 4:43 PM, revealed LPN A took a FlexPen from the medication cart drawer and used an insulin syringe to draw up the medication from the FlexPen into the insulin syringe. LPN A was asked why she drew the insulin out of the FlexPen and did not put a needle on the FlexPen and administer the medication that way. LPN A stated, .ran out of needles for the FlexPens a few days ago .this happened in January, and we were told to do it this way . During an interview on 4/1/2025 at 5:15 PM the Director of Nursing (DON) was asked if she knew they did not have needles for the FlexPens and the staff was using insulin syringes to draw the medication out of the FlexPen to administer insulin to the Residents. The DON stated, I was unaware they were out of needles for the insulin pens . She stated that this happened earlier in the year and the pharmacy said they could do that. When asked who she talked to she was unsure. During a telephone interview on 4/2/2025 at 12:40 PM, the Pharmacist stated that none of the pharmacists recall a conversation about drawing insulin from the FlexPen with an insulin syringe.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when medications were found unsecured and unattended in 2 of 57 (Residents #23 and #47) resident occupied rooms. The findings include: 1. Review of the facility policy titled, MEDICATION STORAGE IN THE FACILITY POLICY, dated 4/2025, revealed .Medications and biologicals must be stored safely, securely, and properly .BEDSIDE MEDICATION STORAGE .Written order in the medical record .Document on MAR [Medication Administration Record] and care plan .store in original/pharmacy containers . 2. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Dementia, Depression and Anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated Resident #23 was moderately cognitively impaired. Review of the Self Administration of Medications, evaluation dated 2/3/2025, revealed .Flonase .Storage . With staff .Resident may self administer medications WITH SUPERVISION .Medication will be stored on med-cart . Review of the care plan updated 3/31/3025, revealed .Medications will be stored in a secure location. Location: med cart . Observation on 3/31/2025 at 9:05 AM, revealed 1 bottle labeled Fluticasone (nasal spray used for allergies) was on the nightstand in Resident #23's room. During an interview on 3/31/2025 9:19 AM, LPN A was asked if medications should be stored at the bedside. Licensed Practical Nurse (LPN) A stated, No During an interview on 3/31/2025 at 2:51 PM, the Administrator was asked if medications should be stored at the bedside. She stated, .no, I heard about that . 3. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE], with diagnoses including Depression, Anxiety, and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated Resident was cognitively intact. An observation and interview on 4/2/2025 at 8:35 AM, revealed a clear medication cup with a white powder in it on a storage bin in Resident #47's room. The Resident was asked what the powder in the medication cup was. She stated, Nystatin [antifungal] powder that they put under my breast at night before bed. LPN B was asked if medication should be stored at the bedside. She stated, No. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 9:02 AM, the Director of Nursing (DON) confirmed medication should not be stored at the bedside.

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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 the facility Infection Control Guide, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 1 nurse (Licensed Practical Nurse (LPN C) failed to wear Personal Protective Equipment (PPE) in an enhanced barrier precautions room. The findings include: 1. Review of the facility manual, [Named Facility] Infection Control Guide, on pages 7 and 8, dated 2025, revealed .Enhanced Barrier Precautions .refers to .the expanded use of PPE during high-contact resident activities .residents with wounds .are at especially high risk .the use of gown and gloves for high-contact resident care activities is indicated . 2. Review of the medical record review revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Pressure Ulcer, Cerebrovascular Disease with Hemiplegia (paralysis on one side of the body), Heart Failure, Peripheral Vascular Disease, Hypertension, and Cachexia (muscle wasting). Review of the Order Summary Report dated 1/15/2025, revealed .Front Left Lateral Leg Stage IV (4) Pressure Ulcer: Cleanse with wound cleanser, pat dry with gauze .apply Negative Pressure Wound Therapy Vac (vacuum) . Monday .Wednesday, Friday . An observation during pressure ulcer care on 4/2/2025 at 9:40 AM, revealed LPN C performed Resident #77's left lower leg ulcer treatment without a PPE gown on in an enhanced barrier room. During an interview on 4/2/2025 at 11:55 AM, (Registered Nurse (RN) D) was asked if a nurse was performing pressure ulcer care on a resident should they wear PPE in an enhanced barrier room. RN D stated, Yes, you should.