

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and two (2) Complaint Investigations (CI) MS #28756 and CI MS#29038 at the facility on 5/18/25 through 5/21/25. The SA investigated CI MS#28756 regarding nursing services, quality of care/treatment and resident/patient client neglect with no deficiencies cited. The SA investigated CI MS#29038 regarding abuse with no deficiencies cited. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M 225, M 815 and M 1020.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day	M 225		6/23/25

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/11/25

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 225	Continued From page 1 shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Pattern Based on observation, interviews, and facility	M 225	1) On 5/21/25, Upon notification that five call lights were alarming: Sufficient nursing staff were dispatched to each residents room to provide needs of residents.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 225	Continued From page 2 policy review the facility failed to ensure sufficient nursing staff were available to meet the care needs of residents during a shift change on three (3) of six (6) resident halls, as evidenced by the facility having one (1) Certified Nurse Aide (CNA) available during the transition from day shift to evening shift, while three nurses remained at the nurse's station, and five (5) resident call lights were observed activated for approximately 30 minutes without response. Findings include: A review of the facility's "Staffing Policy" revealed it is the practice of (Proper Name of Facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staff expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment. The center conducts workforce management meetings daily to discuss open positions and call-ins as related to patient needs. The facility continues to actively recruit staff, offering various incentives. On 5/20/25 at 2:30 PM, the State Agency observed several lights sounding on the North Wing. One light was on in North A Hall, two call lights were sounding in North B Hall, and two call lights were sounding in North C Hall. The State Agency also observed three nurses at the nurse's station-one sitting and two standing-reporting to the oncoming shift. No one answered the call lights. No CNAs were observed on the floor until 2:45 PM. At that time, CNA #8 arrived for the evening shift on the North Unit and began answering call lights. Resident #11 was heard saying, "Will someone please help me?" Upon entering the room, the resident stated her call	M 225	2) All residents have the potential to be affected by this deficient practice. 3) To avoid recurrence of the deficient practice the nursing staff was educated on 5/21/2025, all nursing staff are responsible for answering call lights in a timely manner to ensure residents' needs are met. Education to nursing staff to notify charge nurse when leaving the floor was done on 5/21/2025 by the Director of Clinical Education (DCE). 4) To monitor the performance of our corrective action and to ensure sustainability, the Charge nurse each shift will ensure sufficient Certified Nursing Assistants(C.N.A.s) are assigned along with breaktime/meal times to ensure sufficient staffing on the unit at all times starting 5/21/25. The Administrator and Director of Nursing Services or Assistant Director of Nursing Services will monitor assignment sheets and floor coverage 5 days a week for 6 weeks, then 3 days a week for 6 weeks starting 5/20/2025. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 6/23/2025 by the DNS for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective actions.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 225	Continued From page 3 light had been on for 30 or 40 minutes and that she needed help. On 5/20/25 at 4:10 PM, CNA #2 confirmed there were no CNAs on the floor at 2:55 PM. She also stated she answered the call lights in Rooms N12 and N19. CNA #2 said she did not know where the other CNAs were but confirmed that nurses were present at the nurse's station when call lights were sounding. CNA #2 added that CNAs should notify nurses before leaving the floor and that she had just been informed that CNA #9, scheduled for the North Hall, was sent home on administrative leave at 2:45 PM. On 5/20/25 at 4:30 PM, during an interview, the Assistant Director of Nursing (ADON) stated she did not know where the CNAs were and was unaware that the Administrator had sent CNA #9 home on administrative leave until the State Agency asked about the unanswered call lights on the North Hall around 3:00 PM. On 5/21/25 at 8:00 AM, Licensed Practical Nurse (LPN) #3 confirmed there were no CNAs on the floor at 2:30 PM on 5/20/25. She was unaware that CNAs had left the floor until the State Agency asked to speak with them. She also did not know how long they had been gone. LPN #3 stated CNAs are supposed to report off to the nurses before leaving or going home but often fail to do so. She said administrative staff are aware that CNAs often leave without notification. On 5/21/25 at 8:10 AM, LPN #1 confirmed she was one of the cart nurses on North Hall during the day shift. She stated she did not know CNA #9 had been sent home on administrative leave and that the CNAs had not informed her they were leaving.	M 225		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 225	Continued From page 4 On 5/21/25 at 9:00 AM, CNA #4 confirmed she was assigned to North C Hall. She stated she went outside to dump her barrel before the shift change and did not inform nurses she was leaving the hall. On 5/21/25 at 9:15 AM, CNA #1 confirmed she was assigned to North A Hall and also did not inform the nurses she was leaving the hall. She explained she went to dump her barrel before the next shift. She did not think to notify the nurse and was unaware CNA #9 had been placed on administrative leave. CNA #1 said the hall is often short-staffed. She stated, "We try to do the best we can with what we have." On 5/21/25 at 9:30 AM, CNA #6 stated CNAs do not perform walking rounds to explain care to the oncoming shift. She said dayshift CNAs are often gone before the evening shift arrives. CNA #6 confirmed only one evening shift CNA was on the floor when she arrived. On 5/21/25 at 11:00 AM, CNA #8 confirmed she clocked in at 2:25 PM on 5/20/25. When she arrived on North Hall, call lights were sounding, and no CNAs were on the hall. She observed three nurses at the nurse's station. CNA #8 stated she normally worked as the transportation aide on dayshift but had been working evenings due to staffing shortages. She also confirmed seeing CNAs #4 and #5 outside. On 5/21/25 at 11:30 AM, LPN #2 confirmed she was at the nurse's station at 2:30 PM on 5/20/25 receiving report from LPN #1. She stated that CNAs do not conduct walking rounds and that the dayshift CNAs were not on the hall when she arrived, which she did not know until asked by the	M 225		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 225	Continued From page 5 State Agency. She said she would have helped with call lights if she had known and acknowledged that nurses struggle to assist due to CNA shortages. On 5/21/25 at 12:00 PM, the Administrator confirmed she informed CNA #2 around 2:50 PM that CNA #9 had been placed on administrative leave, which left the North Hall down one CNA. She stated she was unaware the other CNAs were not on the hall. The Administrator acknowledged the facility is actively working to increase staffing and confirmed that available shifts are posted for staff to pick up as needed.	M 225		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Widespread Based on observation, interview, and facility policy review, the facility failed to store food and maintain food quality in accordance with professional standards for food safety related to overly ripe produce and improperly stored foods and unlabeled items during one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, "Food Storage: Cold Foods" revised 2/2023, revealed,	M 815	1) On 5/18/2025, the District Director of Dietary(DMD) discarded all unlabeled food items, expired food items and overly ripe produce and performed 100% audit of dietary department to ensure all items were labeled, dated, and consumable. 2) All residents receiving food from the dietary department have the potential to be affected by this deficient practice. 3) On 5/19/2025 the Dietary staff and Dietary Manager were in-serviced on the Health Care Services Group Policy 18: dry food storage and 19: cold food storage by the DMD. 4) To monitor the performance of our	6/23/25

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 815	Continued From page 6 "...Procedures ...2. All perishable foods will be maintained at a temperature of 41 degrees F or below ..." On 05/18/25 at 10:35 AM, during an observation and interview of the kitchen with the Dietary Manager (DM), refrigerator #3 revealed a plastic storage container containing 14 overly ripe cucumbers with white slimy rind, soft and pliable to the touch, and liquid formed at the bottom of the container. A further observation of the pantry revealed one (1) opened bottle of yellow mustard with the manufacturer's instructions "Best if used by" date of April 17, 2025; one (1) opened gallon-sized bottle of soy sauce with the manufacturer's instructions to "Refrigerate after opening for quality"; 19 overly ripe oranges with green and white bio-growth on the rind; and one (1) overly ripe apple containing a brown soft spot with the interior of the apple exposed. The Dietary Manager acknowledged the overly ripe produce and improperly stored pantry items and stated it is her responsibility to make sure the food is not expired and is stored properly. The DM stated she did not examine the produce that day as she had intended and confirmed the risks of having overly ripe food in the kitchen. The DM noted that going forward she will do a regular check of the produce and pantry items to assure freshness. The DM affirmed that the dietary staff are in-serviced once a month on food safety, which includes lectures and tests. On 05/20/25 at 02:30 PM, in an interview with the Administrator, she acknowledged the overly ripe produce and improperly stored foods. The Administrator stated it is the responsibility of the DM to monitor the food supplies for proper storage and spoilage and stated her expectation is that the DM will get a system of organization to	M 815	corrective action and to ensure sustainability, the DM will audit the dietary department 5 days a week for 6 weeks, then 3 days a week for 6 weeks starting 5/18/2025 to ensure all food is labeled, dated, and stored properly and all expired or spoiled food is discarded immediately. Any negative findings will be brought to the Quality Assurance Performane Improvement meeting monthly for a minimum of three months beginning on 6/23/2025 by the DM for review and revision as necessary. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 815	Continued From page 7 stay on top of monitoring food safety.	M 815		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review, and facility policy review, the facility failed to provide a comfortable, homelike environment in the resident rooms for three (3) of 32 rooms on the North Unit. Findings include: A review of the facility's Resident Rights & Quality of Life Policy, Policy#CC-20, effective March 13,2020 indicated: "The patient or resident has the right to ... receive services in a center environment that is safe, clean, and comfortable ..." On 05/19/25 at 10:43 AM, the State Agent (SA) observed exposed sheetrock surrounding the air conditioner in room N2.	M1010	1) On 5/22/2025 work orders written and repairs made in room N2 regarding exposed sheetrock surrounding the air conditioner by Maintenance Director. On 5/22/2025 work orders written for room N2, N4, and N8 regarding exposed wall areas near the door and air-conditioner, chipped paint, and exposed metal on the bottom corner of wall and repairs were made and completed on 6/10/2025 by the Maintenance Director. 2) All resident's have the potential to be affected by this deficient practice. The Maintenance Director made rounds throughout the facility to check and see if any other rooms had exposed sheetrock surrounding the air-conditioners, exposed wall areas near the door and air-conditioner, chipped paint, and exposed metal on the bottom corner of walls. Work orders written, and negative findings were repaired by 6/10/2025.	6/23/25

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1010	Continued From page 8 On 05/21/25 at 10:05 AM, during a room tour and interview with the Maintenance Supervisor, rooms N2, N4, and N8 were observed to have exposed wall areas near the door and air conditioner, chipped paint, and exposed metal on the bottom corner of walls. The Maintenance Supervisor stated that the damage in room N8 occurred while moving a bed and confirmed that all identified areas were in need of repair. Also, on 05/21/25, during an interview with the Maintenance Supervisor, the SA reviewed maintenance work orders from April to May 2025. The review revealed no documented requests for repairs in room N2 room N4, or room N8. The Maintenance Supervisor admitted that more repair requests are communicated to him verbally during rounds than are formally documented.	M1010	3) On 5/22/2025, the director of Clinical Education provided education to all team members on reporting and creating work orders for any repairs needed. The Maintenance Director will make rounds in 5 rooms 5 days a week to observe for any needed repairs for six weeks and then two times a week for six weeks starting 5/26/2025. The Maintenance Director will check TELS building management daily and make repairs in a timely manner. 4) To monitor the performance of our corrective actions and to ensure sustainability, the embrace partners or the Administrator or Director of Nursing Services will make rounds weekly to ensure all rooms are in good repair starting 5/26/25. Any negative findings of audits will be addressed in the Quality Assurance Performance Improvement meetings for a minimum of three months by the Administrator for review and interventions as necessary beginning with QAPI meeting on 6/23/2025.	