STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	**4728 HIGHWAY 39 NORTH , MERIDIAN, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CIs), MS #472310, MS #2573384, MS #2611481, and MS #2597847, and a Facility Reported Incident (FRI), MS #2612491, at the facility from 9/10/25 through 9/11/25. MS #472310 was investigated for an allegation of insufficient staffing. MS #2573384 was investigated for an allegation of neglect when a resident reportedly fell from her wheelchair and sustained a hematoma and a laceration. MS #2611481 was investigated for an allegation of neglect when a resident sustained a skin tear, which was not reported to the family, and later developed complications. MS #2597847 was investigated for an allegation of misappropriation of resident property when a resident's wallet and birthday gift items went missing. MS #2612491 was a Facility Reported Incident (FRI) investigated for an allegation of verbal abuse when a staff member allegedly directed inappropriate and derogatory remarks toward a resident. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 120 beds, with a census of 97.	F0000		

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 reverse for further 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