| 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 12/17/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **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 |
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| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted Complaint Investigations (CIs), MS #2678116, MS #2690785, MS #2653466, and MS #2638107, at the facility from 12/15/25 through 12/17/25. MS #2678116 was investigated for an allegation of neglect when a resident reportedly fell after sitting in a wheelchair for several hours, was not timely assisted to bed, and staff allegedly made inappropriate comments following the fall. MS #2690785 was investigated for an allegation of neglect and failure to provide appropriate care when a resident reportedly was not turned as required, developed a wound, and staff attitudes toward the resident and family were described as degrading. MS #2653466 was investigated for an allegation of neglect when a resident reportedly developed a rash on her back and family reported staff were not addressing the condition. MS #2638107 was investigated for an allegation of insufficient staffing when the facility was reportedly short staffed, lacked key nursing leadership positions, and assigned nurses an unsafe number of residents. 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.<br><br>The facility held a license for 120 beds, with a census of 102. | 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 |
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