Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TYLERTOWN	**200 MEDICAL CIRCLE P.O. BOX 112, TYLERTOWN, Mississippi, 39667**

(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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 01/11/26 through 1/14/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M715 and M1570.	M0000		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to properly secure and store medications and wound care supplies for two (2) of four (4) days of survey. Findings include: Record review of the facility policy “Medication Storage” updated 04/22 revealed “…Medications are accessible ONLY to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...” On 1/13/26 at 3:07 PM, the wound care cart was observed unattended and unlocked on the resident care unit. The cart remained unsecured until 3:10 PM, when Registered Nurse (RN) #2 was observed walking past and locking it. On 1/13/26 at 3:10 PM, in an interview, RN #2 stated that the wound care nurse was the last to use the cart before going into a resident’s room and must not have locked it. She confirmed the cart should remain locked when not in use to prevent resident access. On 1/14/26 at 9:04 AM, the wound care cart was again observed unlocked and unattended in the hallway. It remained unsecured until 9:07 AM, when RN #1 came down the hall and locked it.	M0715		

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

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M0715	Continued from page 1 In an interview on 1/14/26 at 9:13 AM, RN #3, the wound care nurse, stated that the wound care cart should remain locked at all times when not in use because it contains chemicals that could pose a risk to residents if accessed, ingested, or come into contact with eyes. On 1/14/26 at 9:14 AM, a direct observation of the wound care cart revealed the following items were unsecured and readily accessible: a staple remover, wound cleanser, nystatin antifungal cream, aloe moisturizer, Bio freeze topical anesthetic, triple antibiotic ointment, and iodoform gauze. On 1/14/26 at 9:40 AM, during an interview, RN #1 confirmed that the wound care nurse was the last to access the unlocked cart and reiterated that the cart must be locked when unattended to prevent potential harm to residents. On 1/14/26 at 9:55 AM, during an interview, the Director of Nursing (DON) confirmed that the wound care cart should remain locked at all times when not actively in use to ensure residents do not come into contact with any potentially harmful substances stored in the cart.	M0715		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard	M1570		

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M1570	Continued from page 2 precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection during wound care and medication administration via Percutaneous Endoscopic Gastrostomy (peg) tube for three (3) of (10) care and medication observations. Resident #4, Resident #32 and Resident #49. Findings included: Record review of the facility's policy "Infection Control "dated 11/1/17 revealed, "Policy Statement: This center's infection control policies and practices are intended to facilitate maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infection..." Resident #4 On 01/13/26 at 10:26 AM, during an observation, Resident #4 received Liquid Protein Supplement 30 milliliters (ml) administered by Licensed Practical Nurse (LPN) #1. LPN#1 retrieved the syringe from the pole and attempted to flush peg tube with 30 cubic centimeter (cc) water. She was unable to flush tube. She got a cup off bedside table and poured 30cc water in it. She went to sink in resident room and turned on faucet to get warm water. She checked placement again and attempted to flush peg tube. She was still unable to flush it with 30 cc's of water. She went back to the sink and turned in faucet and to get warm water. She returned and checked placement again. The pump started to beep, and she placed it on hold again at this time she was able to flush line. She administered the liquid protein and flushed with 30 cc's of water after administering protein liquid supplement. LPN #1 did not perform hand hygiene or change gloves throughout the process from the time she entered the room until the actual medication was administered. On 01/13/26 at 2:58 PM, an interview with LPN #1 confirmed that she did not wash hands or change gloves throughout the process. She stated that it left the resident vulnerable to bacteria and germs. Record review of the "Order Summary Report" with active orders as of 1/13/26 revealed physician orders for Liquid protein supplement one time a day for wound healing. Give 30 milliliters (ml) via peg tube.	M1570		

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M1570	Continued from page 3 Record review of Resident #4 “Admission Record” revealed an admit date of 5/9/24 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Dysphagia Oropharyngeal Phase. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident was severely impaired cognitively. Resident #32 Observation on 01/13/2026 at 2:15 PM, LPN #2 was observed giving peg medications to Resident #32 via peg tube. During the process, the nurse put on gloves and touched the bedside pump turning it off with gloves on, then wearing those same gloves to access the peg tube and give the meds. Once she completed the medication administration, LPN#2 used those gloves to turn the pump off, (touching buttons) on the bedside pump with the contaminated gloves. In an interview 1/13/26 at 2:40 PM, with LPN #2, she stated that she should have either used bare hands to turn the pump off or changed gloves after touching the pump prior to accessing the peg tube medications and removed or changed gloves prior to touching the pump at the end of the procedure to turn it off. On 01/14/26 at 9:50 AM, an interview with the Director of Nursing (DON) confirmed that residents have an increase in the chance of infection when hand hygiene is not done. She confirmed that LPN #1 and LPN #2 have should perform hand hygiene and changed gloves during the process. She stated her expectations are for staff to provide care in a way to prevent infection. A record review of Resident #32 "Order Summary Report” with active orders as of 1/13/26 revealed physician orders for Buspirone HCl 10 milligrams (mg), Hydroxyzine 25mg, and Trazadone 50mg via peg tube. A record review of Resident #32 "Admission Record” revealed an admission date of 10/22/25 with diagnoses that included of Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Dysphagia following Cerebral Infarction. A record review of the MDS with an ARD of 10/29/25 revealed a BIMS score of 99 which indicated the resident was unable to complete the interview.	M1570		

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M1570	Continued from page 4 Resident #49 During wound care observation on Resident #49 at 9:17 AM, on 1/13/26, the wound care nurse Registered Nurse (RN) #3 provided wound care starting with an open unstageable wound and was observed cleaning four other separate necrotic wounds to the foot (each one at a separate site), during which she wore the same gloves, reaching the contaminated glove hand into a container filled with saline-soaked gauze and using those gauze to clean a separate wound each time without ever changing her gloves between she then “doubled” back over each wound making a separate pass to clean the each wound again after already cleansing each site while wearing the same gloves. In an interview at 9:40 AM on 1/13/26, with RN #3, stated that she thought the wounds were all considered one wound since they were on the same foot, so it was okay to use the same gloves. In an interview at 11:38 AM on 1/13/26, the DON stated that not changing gloves when you are supposed to can cause cross-contamination to other wounds during the wound care process and lead to infection. In an interview with RN #1, the Infection Preventionist nurse on 1/14/26 at 9:38 AM, stated that not following infection prevention guidelines and changing gloves properly could lead to an increased risk of infection for residents receiving care. A record review of the "Admission Record" revealed the resident was admitted on 11/13/25 with diagnoses that included hypertensive heart and chronic kidney disease. A record review of the MDS with an ARD of 12/18/25 revealed a BIMS score of 13 which indicated no mental impairment.	M1570		