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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255118</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                 |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>01/27/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>DIVERSICARE OF MERIDIAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4728 HIGHWAY 39 NORTH , MERIDIAN, Mississippi, 39301</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| F0000                                                          | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #2722461, CI MS #2722774, and CI MS #2700033), at the facility from 1/26/26 through 1/27/26. CI MS #2722461 and CI MS #2722774 were investigated for abuse, neglects, and resident rights. CI MS #2700033 was investigated for neglect related to pressure sores. 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.</p> <p>The facility held a license for 120 beds, with a census of 100.</p> |                                                                        |  | 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.

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