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 **03/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	**191 HIGHWAY 511 EAST , QUITMAN, Mississippi, 39355**

(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 two (2) Complaint Investigations (CI MS #2791948 and CI MS #2709498), at the facility on 03/16/26 through 03/17/26. CI MS #2791948 was investigated for nursing services and resident/patient/client neglect. CI MS #2709498 was investigated for resident/patient/client abuse and quality of care. 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 M1570.	M0000		
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 precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility policy review	M1570		

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

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M1570	Continued from page 1 and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) and infection prevention and control practices for one (1) of six (6) sampled residents. (Resident #2). Findings include: Record review of the “Infection Control Guide” policy dated 2025 revealed, “…Enhanced Barrier Precautions refers to the expanded use of PPE (personal protective equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing…residents with wounds….are especially high risk…” On 03/17/2026 at 10:40 AM, during an observation of wound care for Resident #2, no signage for EBP was noted on the door. Licensed Practical Nurse (LPN) #1 performed wound care while wearing gloves but did not don (put on) a gown during care. The resident was noted to have a sacral wound with a large amount of grayish drainage and strong odor. LPN#1 performed hand hygiene; however, handwashing duration was observed to be approximately 10 seconds during care and 7 seconds after completion of care. On 03/17/2026 at 10:55 AM, during an interview, the Nurse Practitioner (NP) stated she was aware the resident had a draining wound and a Foley catheter but did not order EBP, stating nursing staff typically initiate those precautions. The NP confirmed the resident had been readmitted from home with a worsening pressure ulcer that progressed from stage 3 to stage 4 and that a wound culture revealed heavy growth of Escherichia coli and Proteus mirabilis, for which Ciprofloxacin was initiated. On 03/17/2026 at 11:00 AM, during an interview Registered Nurse (RN) #1, confirmed that EBP should be implemented for all wound care, especially for advanced pressure injuries, to promote healing and prevent infection. She stated the nurse providing wound care is responsible for following physician orders and applying evidence based wound care standards during each treatment. RN # 1 further stated that failure to implement EBP could result in delayed healing, worsening of the wound, or development of infection. On 03/17/2026 at 11:15 AM, during an interview, the Licensed Nursing Home Administrator (LNHA) acknowledged that based on the resident’s condition, including sacral pressure injuries and documented infection requiring antibiotic therapy, the LPN should have	M1570		

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M1570	Continued from page 2 ensured that Enhanced Barrier Precautions wound care practices were consistently implemented during each dressing change. The LNHA stated that oversight by the RN includes monitoring wound progression, ensuring orders are followed, and verifying that licensed staff are performing wound care according to current standards of practice. Record review of labs results revealed a wound culture collected on 03/10/2026 with results reported on 03/13/2026 showing heavy growth of Escherichia coli and Proteus mirabilis. On 03/17/2026 at 2:45 PM, during an interview Licensed Practical Nurse (LPN) #1 revealed she was responsible for completing wound care treatments as ordered. She stated she typically uses gloves and follows standard precautions but did not identify the requirement for additional transmission-based precautions related to wound care. LPN #1 acknowledged there was no EBP signage posted on the resident's door at the time wound care was provided. LPN #1 confirmed she did not wear a gown during the dressing change. LPN #1 stated she was not aware that a gown was required for this resident during wound care despite the presence of a Stage 3 and Stage 4 pressure injury and wound infection Record review of the "Order Summary Report" with active orders as of 3/17/26 revealed an order dated 3/12/26 for "18 French foley catheter for urinary incontinence and wound healing…" An additional order dated 3/18/26 revealed "Clean stage 4 pressure injury to the sacrum and 3/13/26…" There was also an order dated 3/13/2026 for "Ciprofloxacin 250 mg (milligrams) by mouth twice daily for 14 days." Record review of Resident # 2's "Admission Record" revealed an admission date of 03/04/2026 with a prior admission date of 11/18/2025 with diagnoses that included cerebral infarction due to embolism of the left carotid artery. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/10/26 revealed the resident is rarely/never understood and staff completed the mental status assessment. Section M indicated the resident had unhealed pressure ulcers/injuries	M1570		