

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 04/08/2026	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN				STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH , MERIDIAN, Mississippi, 39301			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #2795342) at the facility from 4/07/26 through 4/08/26. CI MS #2795342 was a facility reported incident regarding misappropriation of property. During the survey, the SA determined that based on implementation of the facility's corrective actions on 03/05/2026, the facility was in compliance with requirements for participation in Medicare and Medicaid. The deficient practice was determined to be Past Non-Compliance (PNC), and the facility was in compliance effective 03/06/2026 and was cited F602.		F0000				
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the resident's right to be free from misappropriation of resident property for one (1) of three (3) residents sampled. Resident #1. Findings include: A review of the facility's "Abuse, Neglect, Misappropriation, Exploitation Policy"," dated January 2019 revealed, "...Purpose: To prohibit and prevent...misappropriation of resident property...Definitions...Misappropriation of Resident Property: The deliberate misplacement, exploitation, or		F0602	"Past Noncompliance - no plan of correction required"			

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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F0602 SS = D	Continued from page 1 wrongful, temporary or permanent use of a resident's belongings...without the residents consent..." A record review of the facility's "Investigation Template", dated 03/06/2026, revealed that on 03/04/2026, at approximately 7:57 AM, as the hospice nurse was providing postmortem care to Resident #1, Certified Nursing Assistants (CNAs) # 1, 2, 3, 4 and 5 entered the room and proceeded to take his personal belongings from his room. These items included drinks, toilet tissue, bed pads, a cup, and a blanket. A review of the "Investigation Summary" revealed, "After investigation of incident, it was determined the intent was there for misappropriation. All items were returned. Five team members terminated and one contracted housekeeper will not be returning to center." Further review of the investigation revealed a statement from CNA #1 that revealed "I got to work and clocked in at 6:10AM, I saw night shift at the door of (Proper Name for Resident #1) room, and I saw (Proper names for CNA #3 and #5) in the room. I noticed that stuff was missing from the room (Proper names for CNA #3 and #5) were taking stuff out of the room, I took garbage bags and towels out of the room and placed them at the nurse's station to get later because I don't have a car. (Proper name of staff) came into the room, the Hospice nurse was asking for pads, there were none in the room and there should have been pads. (Proper name for CNA #2) came and took tissue and mouthwash. (Proper name for CNA #4) took a large tumbler out of the room. I saw (proper name for CNA #5) take reading glasses, air fresheners and bed bags out of the room and she placed them behind the hamper in her mother's room." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 11/10/2025 with current diagnoses including Heart Failure. A record review of the Death in Facility Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/2026 revealed Resident #1 died in the facility. A record review of the "Progress Notes," dated 3/4/26 at 5:32 AM, revealed Resident #1 was found unresponsive and there was no respirations or pulse noted by the nurse. A record review of the "Progressive Discipline Form" for CNA #1 revealed the CNA was placed on "Administrative Leave" on 3/4/26 and the "Summary of Incident" included, "...it as alleged that personal items of a deceased resident had been removed from his room..." There was another "Progressive Discipline			F0602			

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F0602 SS = D	Continued from page 2 Form" for CNA #1 that revealed the CNA was terminated on 3/9/26 with the "Summary of Incident" of "...Following an investigation it was determined that your actions demonstrated an intent for misappropriation." A record review of the "Progressive Discipline Form" for CNA #2 revealed the CNA was placed on "Administrative Leave" on 3/4/26 and the "Summary of Incident" included, "...it as alleged that personal items of a deceased resident had been removed from his room..." There was another "Progressive Discipline Form" for CNA #2 that revealed the CNA was terminated on 3/9/26 with the "Summary of Incident" of "...Following an investigation it was determined that your actions demonstrated an intent for misappropriation." A record review of the "Progressive Discipline Form" for CNA #3 revealed the CNA was placed on "Administrative Leave" on 3/4/26 and the "Summary of Incident" included, "...it as alleged that personal items of a deceased resident had been removed from his room..." There was another "Progressive Discipline Form" for CNA #3 that revealed the CNA was terminated on 3/9/26 with the "Summary of Incident" of "...Following an investigation it was determined that your actions demonstrated an intent for misappropriation." A record review of the "Progressive Discipline Form" for CNA #4 revealed the CNA was placed on "Administrative Leave" on 3/5/26 and the "Summary of Incident" included, "...it as alleged that personal items of a deceased resident had been removed from his room..." There was another "Progressive Discipline Form" for CNA #4 that revealed the CNA was terminated on 3/9/26 with the "Summary of Incident" of "...Following an investigation it was determined that your actions demonstrated an intent for misappropriation." A record review of the "Progressive Discipline Form" for CNA #5 revealed the CNA was placed on "Administrative Leave" on 3/4/26 and the "Summary of Incident" included, "...it as alleged that personal items of a deceased resident had been removed from his room..." There was another "Progressive Discipline Form" for CNA #5 that revealed the CNA was terminated on 3/9/26 with the "Summary of Incident" of "...Following an investigation it was determined that your actions demonstrated an intent for misappropriation."			F0602			

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F0602 SS = D	Continued from page 3 On 04/07/2026 at 10:24 AM, during an interview with CNA #2 she disclosed that someone (name unknown by CNA #2) told her that Resident #1 had passed away. CNA #2 stated that she went into the resident's room and found several workers in the room. CNA #2 confirmed that she took a pack of toilet paper and put it in a bag and took it to her car. CNA #2 noted that another CNA (name unknown by CNA #2) told her that someone was going to tell, so she went back to get the tissue from the car. CNA #2 affirmed that the resident was still in the room at the time that she took the tissue. CNA #2 reported that she understood that the tissue belonged to the resident and that taking it was stealing. CNA #2 noted that everything could have been avoided because she didn't need the tissue. CNA #2 confirmed that she lost her job over a pack of toilet tissue. CNA #2 stated that if she had it to do again, she would not have gone into that room. On 04/07/2026 at 10:33 AM during an interview with CNA #3 she stated that a CNA (name unknown by CNA #3) from that hall came to tell her that Resident #1 had expired. CNA #3 stated that while the resident was still in the room, having recently expired, she took 2 cases of citrus flavored punch and 2 jugs of fruit punch and placed it behind the nurse's station. CNA #3 stated she recognized that the punch belonged to Resident #1, but she took the resident's belongings because he was deceased and it would be thrown away. CNA #3 acknowledged that only the Resident Representative has the authority to remove or claim personal belongings from a resident's room. CNA #3 confirmed that she did not receive authorization from the Resident Representative, prior to removing things from his room. CNA #3 stated she has been a CNA for 44 years and if she had it to do again, she would not have anything to do with it. CNA #3 stated she knows she was wrong and that she feels regret over her choice to remove the resident's belongings from his room. CNA #3 stated she knows there are consequences behind bad choices. On 04/07/26 at 10:40 AM during an interview with CNA #4 she revealed that when Resident #1 passed away one of the CNA's (CNA #4 could not recall the name) walked in Resident #1's room and said "Hey, we might as well get this stuff." CNA #4 stated she took a pack of drinks (sodas), a blanket and a cup. CNA #4 confirmed that the resident was still lying in the bed, having recently expired, as she took his personal belongings from his room. CNA #4 stated she returned the blanket and the cup when she was questioned by the Director of Nursing (DON). CNA #4 reported that she has been a CNA for 10 years. CNA #4 noted that she felt peer pressure to take			F0602			

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F0602 SS = D	Continued from page 4 the things. CNA #4 stated she feels remorse and that she knew better. On 04/07/2026 at 11:00 AM, during an interview with CNA #5 she stated that the day before the resident passed away, he told her that she could have some protective bed pads that he had in his closet. CNA #5 stated that the resident was always giving away his bed pads to other residents. CNA #5 noted that she should have taken the pads the day before when they were offered, because it was wrong to wait until after he was deceased to take them. On 04/08/2026 at 9:01 AM, during an interview with the Director of Nursing Services (DNS) she revealed that on 03/04/26 at 7:52 AM she received a call from the Admissions Coordinator, RN Registered Nurse (RN) #1, to relay a report from the Hospice Nurse regarding staff taking personal belongings from Resident #1, who had passed away that morning. The DNS stated that when she arrived, she spoke with two CNAs for witness statements. The DNS reported that she then interviewed the CNAs seen in the room. The DNS stated that as soon as the CNAs gave their statements, four were put on Administrative Leave immediately. The DNS stated that CNA #4 was sent home on administrative leave on 03/05/26 because she was not honest when initially questioned. The DNS noted that with additional information CNA #4 was called back in and put on leave on 03/05/26. The DNS stated that the staff were in-serviced on misappropriation of personal property and staff were no allowed to work until they were in-serviced. On 04/08/2026 at 9:10 AM, during an interview with RN #1 (Charge Nurse at the time of the incident) revealed that on the day of the incident she had arrived at work at approximately 6:45 AM. RN #1 stated the Hospice Nurse was bathing Resident #1 who had recently expired resident. RN #1 reported that while she was assisting the hospice nurse, the hospice nurse reported that multiple CNAs had entered the room as she was cleaning the resident and proceeded to take personal belongings from the resident's room. RN #1 stated that she reported this information to the DNS. On 04/08/2026 at 9:23 AM, during an interview with the Administrator, she revealed that on the morning of the incident she received a group text from the Hospice company's Executive Director stating that the Hospice Nurse had reported that the facility's staff had taken belongings from a residents' room. The Administrator stated she contacted the DNS and was informed that she had interviewed the staff, called law enforcement and		F0602				

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F0602 SS = D	Continued from page 5 had placed four of the CNAs on administrative leave. The Administrator stated that additional information caused them to reinterview a CNA the next day and place a 5th CNA on administrative leave. The Administrator stated that all staff were in-serviced on misappropriation of personal property. A review of the facility's correction plan dated 3/04/2026, revealed the DNS made an attempt to contact the Resident Representative (RR) for Resident #1, but was unsuccessful. The plan detailed that an investigation was conducted starting 3/4/26, resulting in CNAs #1, 2, 3, and 5 were interviewed and suspended on 03/04/2026 as well as the contracted housekeeper not allowed to return to the facility. On 03/05/2026 CNA #4 was interviewed and suspended. On 03/04/2026, the facility contacted local police department to make a report of the incident. On 03/04/2026 the facility made a report of the incident to the State Agency. On 03/04/2026 the facility notified the Medical Director. The plan included the Social Services Director interviewing residents with a Brief Interview for Mental Status (BIMS) of 12 or higher and the Resident Representatives (RRs) for residents with a BIMS of 11 or lower regarding possible missing items. On 03/04/2026 an in-service on Abuse/Neglect/Misappropriation, Elder Justice act and Customer Service Standards was conducted by the DNS, Assistant DNS, and Administrator with no staff allowed to work until in-service was completed. A Quality Assurance and Performance Improvement (QAPI) meeting was held on 03/04/2026. To ensure system compliance, the SSD will interview three (3) residents weekly for twelve (12) weeks to ensure residents' belongings are not missing. Based on the implementation of the facility's corrective actions that were completed on 03/05/2026, the deficient practice was determined to be Past Non-Compliance (PNC), and the facility was in regulatory compliance effective 03/06/2026. Validation: The SA validated on 04/08/2026, through interview and record review, that all corrective actions had been implemented as of 03/05/2026, and the facility was in regulatory compliance on 03/06/2026, prior to the SA's entrance on 04/07/2026.		F0602				