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 **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI MS #2988580), at the facility from 5/4/26 to 5/5/26. CI MS #2988580 was a Facility Reported Incident (FRI) regarding a fall during a mechanical lift transfer, that resulted in a head laceration. During the survey, the SA determined that based on implementation of the facility's corrective actions on 4/19/26, the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The deficient practice was determined to be Past Non-Compliance (PNC), and the facility was in compliance effective 4/20/26 and was cited M640.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility lift guidelines review, the facility failed to ensure the correct sling type and size were used during a mechanical lift transfer which resulted in Resident #1 falling from the lift and sustaining a subarachnoid hemorrhage (bleeding around the brain) for one (1) of four (4) sampled residents. Findings include: A review of the facility's "Lift 4 Care – Safe 4 All" Guidelines, dated 5/2024, revealed, "Purpose: To provide team members guidance with assisting patients and residents to safely reposition or transfer. Guideline…7. In order to maintain patients' and residents' safety, patients and residents should be lifted or transferred by the lift and sling which is deemed appropriate after the lift evaluation is completed. There should be no interchanging of lifts and slings…" A review of the facility's "Investigation Template,"	M0640		

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

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M0640	Continued from page 1 dated 4/22/26, revealed, "…Incident Date: 4/18/26….Time: 7:00 PM…Description of the Allegation: Resident experienced a witnessed fall during transfer. Laceration to back of head. Resident was transferred to the hospital and returned within 24 hours at the same baseline as prior to the fall…Investigation Summary…She was identified as needing a full lift with sling to accommodate her body weight of 103 and body type…The center staff conducted a root cause analysis of the event and determined the sling was not appropriate size for the resident…" A record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/13/13 with diagnoses including Flaccid Hemiplegia Affecting Right Dominant Side and Acquired Absence of Right Leg Above Knee with an onset date of 1/7/25. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/30/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact. A record review of the "Order Summary Report," with Active Orders As Of: 4/30/26, revealed Resident #1 had a Physician's Order, dated 9/25/26 for Eliquis (a type of blood thinner) 5 milligrams (mg) two times daily. A record review of the Medication Administration Record (MAR) for April 2025 revealed Resident #1 was administered Eliquis 5 mg two times daily for Atrial Fibrillation. A record review of the Kardex revealed Resident #1 required "Hoyer (type of full body mechanical lift) Total Lift Small (RED) Sling," "Provide Hoyer sling for right side amputation," and "TRANSFER: The resident uses a total lift with small red sling…" A record review of the "H&P (History and Physical)," dated 4/19/26 at 1:57 AM from the acute hospital, revealed, "…104 y.o. (year old)…Presents as transfer from (local acute hospital) after falling out of a hoyer lift at her nursing home…she has a right occipital laceration which was repaired with staples at the outside hospital…Care Timeline 04/19(2026) Discharged 0901 (9:01 AM)… Clinical impressions subarachnoid hemorrhage…Disposition Discharge Condition Stable…" On 5/4/26 at 11:47 AM, during a telephone interview with the Power of Attorney (POA) and daughter of Resident #1, she explained facility staff informed her	M0640		

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M0640	Continued from page 2 a sling had been left under Resident #1 while in the wheelchair and the sling used was too small and not one typically utilized by the facility. The POA explained staff informed her the sling may have originated from another facility or outside provider and was somehow placed into the facility's inventory. The POA explained Resident #1 sustained a brain bleed as a result of the fall, was initially sent to a local hospital, and was later transferred to another hospital out of town for a second Computed Tomogaphy (CT) scan. On 5/4/26 at 1:58 PM, during an interview with Certified Nursing Assistant (CNA) #6, she explained staff determined the appropriate sling for each resident by reviewing the Kardex prior to transfers and staff typically check this information each time a transfer is performed. CNA #6 explained an amputee sling differs from a standard sling because it extends from the back to the knees and requires two (2) staff members to safely complete the transfer. On 5/4/26 at 2:14 PM, during an interview with Licensed Practical Nurse (LPN) #1 regarding the incident involving Resident #1 on 4/18/26, LPN #1 explained she was present at the time of the incident and assisted the CNA with transferring Resident #1 from the wheelchair to the bed. LPN #1 explained she could not recall the color of the sling used during the transfer. LPN #1 explained the incident occurred quickly during the evening hours and Resident #1 struck her head on the leg of the mechanical lift. LPN #1 explained she instructed the CNA to notify nursing staff and initiate a call to Emergency Medical Services (EMS). LPN #1 explained Resident #1 sustained a head laceration with active bleeding and gauze was applied to control the bleeding until further medical assistance arrived. On 5/4/26 at 2:40 PM, during an interview with the Director of Nursing (DON), she explained she came to the facility after being notified of the incident and observed Resident #1 had been transferred using a black sling, which was not consistent with the facility's standard equipment. The DON explained she removed the sling from Resident #1's room following the incident and discarded it. The DON explained a search of the facility was conducted to identify any additional slings without weight indicators or identification and no other similar slings were found. On 5/4/26 at 3:11 PM, during an interview with CNA #8 regarding the transfer incident involving Resident #1 on 4/18/26, CNA #8 stated during the transfer	M0640		

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M0640	Continued from page 3 she requested assistance from nursing staff. CNA #8 stated during the transfer Resident #1 shifted in the sling and fell out of it. CNA #8 stated Resident #1 had a black sling underneath her while sitting in the wheelchair on the day of the incident. CNA #8 stated it was unknown where the black sling originated and confirmed she had not previously used that sling for Resident #1 or any other resident. CNA #8 stated because the sling was already positioned underneath Resident #1 while in the wheelchair, she thought it was acceptable to use. A record review of the facility's plan of correction revealed Resident #1 was being transferred from the wheelchair to the bed when Resident #1 slid out of the sling. The Administrator (ADM) and Director of Nursing Services (DNS) initiated an investigation on 4/18/26. The Nurse Practitioner (NP), Responsible Party (RP), ADM, DNS, and Medical Director were notified on 4/18/26. Licensed Practical Nurse (LPN) staff received an order on 4/18/26 to transfer Resident #1 to the Emergency Room (ER) for evaluation. DNS reviewed and updated Resident #1's Kardex and plan of care on 4/18/26 as required and removed the lift and sling from use on 4/18/26. All residents requiring lift transfers were identified as potentially affected on 4/18/26. Maintenance staff were directed by DNS on 4/18/26 to check all lifts for proper functioning. Staff were directed on 4/19/26 to check all slings for fraying and worn areas and to remove damaged slings from use as required. All residents were to be reevaluated for lift and transfer needs, including ensuring the correct sling type and size were used on 4/19/26. DNS completed immediate in-service training with LPN and Certified Nurse Aide (CNA) staff on 4/18/26 with return demonstration regarding lift use. DNS initiated in-service training with all nursing staff on 4/18/26 regarding the correct lift, sling type, and sling size to use. DNS and Assistant Director of Nursing Services (ADNS) initiated abuse and neglect in-service training with all staff on 4/18/26. DNS, ADNS, and Unit Manager (UM) retrained all nurses and CNAs on 4/18/26 regarding lift and transfer procedures, ensuring the correct sling type and size were used, the location of the Kardex, and verbal knowledge of following the resident's plan of care. DNS and ADNS implemented ongoing audits to monitor corrective actions and ensure sustainability. Audits of one hundred percent (100%) of newly admitted, readmitted, and current residents completed quarterly, annually, and with significant change to ensure residents were assessed for the correct lift, sling size, and sling type, with corresponding care plan and Kardex updates. Any negative findings reported to the Quality Assurance	M0640		

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M0640	Continued from page 4 Performance Improvement (QAPI) committee monthly for a minimum of three (3) months beginning April 2026 for review and revision as necessary. Due to the facility's corrective actions on 4/18/26 and 4/19/26, the deficient practice was determined to be past noncompliance. Validation: The SA validated on 5/5/26, through interview and record review that all corrective actions had been implemented as of 4/19/26, and the facility was in compliance as of 4/20/26 prior to the SA's entrance on 5/4/26.	M0640		