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 **05/21/2026**

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

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M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey and Complaint Investigation (CI) MS #2980096 at the facility from 05/18/26 through 05/21/26. The SA investigated CI # 2980096 for quality of care, nutrition and weight loss. There was no citation related to the complaint investigation. 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 M500 and M655.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider	M0500		

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

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M0500	Continued from page 1 meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another	M0500		

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M0500	Continued from page 2 health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as	M0500		

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M0500	Continued from page 3 evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's call light remained accessible and within reach for one (1) of (20) sampled residents reviewed for call light accessibility. Resident #77. Findings include: A review of the facility's policy, "Nurse Call Policy," dated 9/1/2014, revealed, "…Guidelines…2. Each cord needs to be visible and reachable by the resident which it operates for…4. Any component that does not function should be repaired as soon as practically feasible…" A record review of the "Admission Record" revealed the facility admitted Resident #77 on 1/18/24 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/26 revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact. On 5/18/26 at 11:51 AM, during an observation and interview, Resident #77's call light string was observed out of the resident's reach. Resident #77 stated the string was out of reach and she would not have been able to call for assistance if needed. The call light system required the resident to pull the string to activate the call light outside the resident's room and at the nurses' station. On 5/18/26 at 12:04 PM, during an observation and interview, Certified Nursing Assistant (CNA) #1 entered Resident #77's room and picked the call light string up from the floor. The call light string did not have a clip attached to the end. CNA #1 explained the clip must have fallen off and without a clip, the call light string would not attach to the resident's clothing or bedding. CNA #1 reported the string may have fallen out of reach while she was adjusting the bed. She was unable to recall how long the clip had been missing from the call light string. There was no clip visible on the floor or near the bed. On 5/20/26 at 2:34 PM, during an interview, CNA #2 stated staff were trained to ensure residents' call lights remained within reach when exiting resident rooms and to ensure resident needs were addressed prior to leaving the room.	M0500		

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M0500	Continued from page 4 On 5/21/26 at 11:04 AM, during an interview, the Director of Nursing (DON) stated nursing staff were responsible for reporting equipment concerns to maintenance and could submit requests through the Technology for Equipment and Life Safety (TELS) work order system in the electronic health record. On 5/21/26 at 11:35 AM, during an interview, the Housekeeping/Maintenance Director (HM) #1 stated call light systems were checked monthly, and staff could submit maintenance requests verbally or through the TELS system. HM #1 stated no maintenance request had been verbally received or received in TELS regarding repair of Resident #77's call light and explained that maintenance requests submitted through the TELS system generated immediate notifications to his cellular phone. On 5/21/26 at 2:37 PM, during an interview, the Administrator stated staff were expected to report maintenance concerns through the appropriate process and ensure Resident #77's call light clip was replaced. The Administrator stated staff should have monitored Resident #77 more frequently until the call light clip was repaired.	M0500		
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to store oxygen tubing and a nasal cannula in a manner to prevent possible contamination and respiratory complications for one (1) of (1) residents reviewed for respiratory care. Resident #29. Findings include: A review of the facility's policy, "Oxygen Guideline," dated 8/1/2024, revealed, "…Medical oxygen…is provided in accordance with a health care provider's order and in accordance with acceptable standards of practice." A record review of the "Admission Record" revealed the facility admitted Resident #29 on 1/19/25 with	M0655		

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M0655	Continued from page 5 diagnoses including Diabetes Mellitus (DM). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact. A record review of the “Order Summary Report” revealed Resident #29 had a physician order dated 5/8/26 for “Oxygen at 2L (liters) per nasal cannula for decreased oxygen saturation PRN (as needed) for decreased saturation.” On 5/18/26 at 10:45 AM, during an observation, Resident #29 was sleeping in bed. Oxygen signage was observed on the resident’s door. Resident #29 was not wearing the nasal cannula at the time of the observation. An oxygen concentrator was in the resident’s room with the nasal cannula tubing lying on top of the concentrator with the nasal cannula exposed and not stored in a protective bag. On 5/20/26 at 2:45 PM, during an observation and interview, Resident #29 was in bed and stated he had not worn his oxygen in a couple of weeks. The oxygen concentrator remained in the room with the tubing lying on top of the concentrator and the nasal cannula exposed and not stored in a protective bag. On 5/20/26 at 3:00 PM, during an observation and interview with the Director of Nursing (DON), she confirmed the oxygen tubing and nasal cannula were stored with the nasal cannula exposed. The DON explained the tubing should have been stored in a bag. The DON stated she expected staff to ensure nasal cannula tubing was stored appropriately and reported Resident #29’s oxygen was ordered PRN and she would have the oxygen concentrator removed from the room.	M0655		