STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Southaven	1730 Dorchester Dr Southaven, MS 38671

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff and resident interviews, record reviews, the facility's investigation, and the facility clinical care system guidelines review, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as an elopement and wandering risk, from exiting the facility unnoticed and unsupervised for one (1) of three (3) residents reviewed for accident hazards (Resident #1). The facility's failure to provide supervision resulted in Resident #1 exiting the facility unnoticed and unsupervised. She was determined to have exited the facility on 2/14/26, at approximately 1:08 PM and was located by staff 0.4 miles from the facility at 1:33 PM. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 2/14/26, and existed at 42 CFR: 483.25(d)(1)(2) - Free of Accident Hazards/Supervision/Devices (F689) - Scope and Severity J. This situation placed Resident #1 and other residents at risk for wandering and elopement in a situation likely to cause serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 2/18/26, at 4:08 PM and provided the Administrator with the IJ template. The facility provided an acceptable Removal Plan on 2/19/26 in which they alleged all corrective actions to remove the IJ were completed on 2/18/26 and the IJ removed on 2/19/26. The SA validated the Removal Plan on 2/20/26 and determined the IJ and SQC was removed on 2/19/26, prior to exit, and the scope and severity for F689 was lowered from a J to a D, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.Findings Include: A review of the facility's clinical care system guidelines, Elopement, revealed, Purpose to establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements. Process: On admission, newly admitted or re-admitted residents are assessed for elopement risk. If an elopement risk is determined, an individualized plan is established, and intervention is initiated to mitigate that risk. When the nurse identifies the intervention, it is documented on the care plan and on the caregiver guide. A photograph of the resident is taken to assist with identification if necessary. There is a central system (i.e., nurse's station, reception area) where information, including a photograph regarding all those identified at risk is located.Door Alarm Protocol: Team members know how to respond to all door/exit alarms. Once door/exit alarms are activated, a resident search is completed ensuring there is no missing resident . A record review of the facility's investigation revealed that around 1:00 PM on 2/14/26, staff noticed that Resident #1 was no longer on the unit. Upon checking Resident #1's room, it was noted that she was not present. The nurse called a missing resident code. Another resident informed staff that she had seen a lady in pink walking outside her window. Staff went outside, located the resident, and brought her back into the facility. Record review of the Clinical Health Status Evaluation, Elopement Risk, dated 2/14/26, at 12:41 AM, for Resident #1 revealed, Based on Risk Assessment, is resident at risk? Yes. Narrative: Resident has a wander guard in place. Record review of Assessment (continued on next page)

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 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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Outcomes, the Brief Interview for Mental Status (BIMS) score on 2/14/26, was zero (0), indicating that Resident #1 was severely cognitively impaired. Record review of the admission Record revealed that the facility admitted Resident #1 on 2/13/26, with diagnoses that included UNSPECIFIED DEMENTIA, MODERATE, WITH OTHER BEHAVIORAL DISTURBANCE, and WANDERING IN DISEASES. During an interview with Licensed Practical Nurse (LPN) #2 on 2/18/26, at 9:15 AM, she stated she was assigned to Resident #1 on 2/14/26. She verified that she was aware the resident wandered and was at risk for elopement. She stated the resident had a wander guard in place and confirmed she had last seen the resident right after lunch walking up and down the halls. LPN #2 further stated that at approximately 1:00 PM, she noticed Resident #1 was no longer in the hallway. She asked the Certified Nursing Assistants (CNA) to check the resident's room, and when she was not there, she called a missing resident code. LPN #2 stated another resident told staff that they had seen a lady in pink walking outside her window. Staff went outside and brought the resident back inside. Interview and observation with Resident #1 on 2/18/26, at 10:30 AM, she stated that she did go outside on 2/14/26. She stated she had been sitting at a table with others, and when they left, they did not tell her where they were going. She stated she did not want to be left alone, so she followed them out. Interview with CNA #1 on 2/18/26, at 11:00 AM, she stated she had last seen the resident right after lunch walking the halls. While picking up lunch trays at approximately 1:00 PM, the nurse asked if she had seen Resident #1 recently and asked her to check the resident's room. When the resident was not present, the nurse called a missing resident code. She and another CNA went outside, and the resident was located in the neighboring subdivision. She confirmed that they brought the resident back to the facility. Telephone interview with Receptionist #1 on 2/18/26, at 1:23 PM, stated that on 2/14/26, around 1:00 PM, a visitor was leaving and a lady in pink was with her. She stated she let the visitor out, and the lady in pink followed her outside. She stated she was not aware the lady was a resident. Receptionist #1 stated that they have an elopement book at the desk, and when the facility admits a resident who wanders or is at risk for elopement, nursing staff notify her and provide a picture and information to add to the book so she will know who is at risk and prevent them from exiting. She stated she was not notified that Resident #1 was at risk for wandering or elopement and that there was no information in the elopement book. She stated the door alarm did not sound when she let the resident out. She stated she later learned the individual was a resident when staff asked her if she had seen Resident #1. She also stated the alarm had been activating intermittently throughout the day with no residents being present, and the alarm company had contacted the facility, and she referred them to Maintenance. Interview with Maintenance on 2/18/26, at 3:02 PM, he stated he came to the building on 2/14/26, after the incident, and checked all door alarms and found no malfunction. He stated he reviewed video footage showing Receptionist #1 turned the alarm off after the visitor and Resident #1 exited the building. Interview with the Administrator on 2/18/26, at 3:15 PM, she stated the video was no longer available due to automatic overwriting; however, she verified that her review of the video from 2/14/26 showed Receptionist #1 turned the alarm off after the visitor and Resident #1 exited. She also verified the elopement book did not contain a picture or information regarding Resident #1 being at risk for elopement at the time of exit. The facility submitted an acceptable Removal Plan on 2/18/26, and the IJ was removed on 2/19/26. On 2/14/2026, LPN #1 identified Resident #1 was no longer in the hallway and began searching for her on 2/14/2026, at approximately 1:00 PM. Staff members implemented the elopement guideline immediately on 2/14/26, at approximately 1:10 PM. Staff members immediately completed a room-to-room audit of all residents to assure all were safe on 2/14/26, beginning at 1:10 PM. On 2/14/2026, at approximately 1:33 PM, Resident #1 was returned safely to her room by LPN #1. No (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	distress was noted. Resident #1 was wearing a wander guard upon return and was checked for functionality upon return to the building on 2/14/26, at approximately 1:33 PM by LPN #1. It was functioning as designed. A full body audit of Resident #1 was performed immediately upon her return by LPN #1 on 2/14/2026, at approximately 1:35 PM. There were no negative findings identified. Resident #1 was immediately placed on 1:1 supervision on 2/14/2026, at approximately 1:35 PM and a request for psychiatric consultation was placed by the Director of Nursing Services (DNS). Resident #1 was to remain on 1:1 supervision pending psychiatric consultation. Following removal of 1:1 supervision, the facility will ensure visual observations every thirty minutes for twenty-four hours and continued as needed. The DNS reviewed Resident #1's plan of care to ensure reflection of elopement risk and updated it on 2/14/26, at approximately 3:00 PM. All doors were checked for proper function and operation immediately on 2/14/26, at 3:05 PM by Maintenance. All doors were functioning properly. The facility determined that Resident #1 followed a visitor and exited at the front entrance on 2/14/2026, at 1:08 PM. The door alarm system functioned appropriately. The Medical Director was notified by the DNS on 2/14/26, at approximately 2:00 PM. Resident Representative of Resident #1 was notified by LPN #1 on 2/14/26, at approximately 2:00 PM. On 2/14/2026, a 100% audit of all residents identified for elopement risk was completed by the DNS to ensure placement and functioning of the wander guard system. An audit of elopement books located on all units and reception was completed by the DNS on 2/14/2026, to ensure pictures and care plans were present for all at-risk residents. Elopement drills were completed on all shifts on 2/14/26, by Maintenance. The Receptionist was educated on elopement guidance with emphasis on prompt response and investigation of alarm activation on 2/14/2026, by the DNS. The Receptionist was placed on administrative leave on 2/14/2026. The DNS and Assistant Director of Nursing Services immediately initiated an in-service on 2/14/2026, with nursing staff regarding elopement guidelines, including completion of risk assessments, care plan updates, and elopement book updates. The DNS and Assistant Director of Nursing Services initiated additional staff education on elopement guidelines and abuse and neglect on 2/14/2026. Education was provided to Social Services on 2/16/2026, by the Director of Clinical Operations on elopement guideline oversight. On 2/15/26, the DNS returned to the facility to educate staff and monitor effectiveness. On 2/16/2026, the DNS returned to educate staff and monitor effectiveness. On 2/18/2026, the DNS educated House Supervisors and Managers on Duty regarding elopement book accuracy. No staff member will be permitted to work without completing education. On 2/14/2026, facility leadership conducted a QAPI (Quality Assurance and Performance Improvement) meeting to address root cause and corrective action. All corrective actions were completed on 2/18/26, and the facility alleged the IJ was removed on 2/19/26. Validation: The State Agency validated the Removal Plan on-site during Complaint Investigation (CI) #2744403 and CI #2744399 through record review and interviews on 2/20/26. The SA determined all corrective actions were completed on 2/18/26, and the IJ was removed on 2/19/26.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure medications were available and administered as ordered for one (1) of three (3) resident reviewed for significant medication errors. (Resident #4). Findings Include:Record review of the facility Medication Availability form, identified by the Nurse Consultant as the facility protocol for missing medications, revealed, If medication is not available at administration time: Check E Kit (Emergency Medication Kit), call the pharmacy, obtain estimated time of delivery, notify supervisor. If greater than four (4) hours, call Medical Doctor (MD) to inform and obtain plan to address. Record review of the January 2026 Electronic Medication Administration Record (eMAR) for Resident #4 revealed that on the night of admission, 1/9/26, Resident #4 had physician orders for Terazosin Hydrochloride (HCL) oral capsule 1 milligram (MG), give one (1) capsule by mouth one (1) time a day related to Essential Hypertension, scheduled at hour of sleep (HS); Dabigatran Etexilate Mesylate oral capsule 150 mg, give one (1) capsule by mouth two (2) times a day related to Paroxysmal Atrial Fibrillation, scheduled at HS; and Morphine Sulfate oral tablet 30 mg, give one (1) tablet by mouth two (2) times a day for pain related to Rheumatoid Arthritis. Administration of all three (3) medications was documented as code seven (7), which indicates Other/See Progress Notes, indicating the medications were not administered as ordered. Record review of Progress Notes, dated 1/9/26, and timed 11:48 PM, for Resident #4 revealed documentation stating, awaiting medications, with no further documentation to indicate the medications were obtained or administered in accordance with facility protocol. Interview with Licensed Practical Nurse (LPN) #2 on 2/19/26 at 11:40 AM revealed that when a new resident is admitted , medication orders are transmitted to the pharmacy for dispensing and delivery. She stated that if a medication is not available, staff may obtain medications from the Emergency Medication Kit (E Kit). She further stated that if the medication is not available in the E Kit, staff may contact the pharmacy, including the backup or emergency pharmacy for after-hours needs, to obtain the medication. LPN #2 stated that failure to administer Resident #4's prescribed medications could result in adverse outcomes including elevated blood pressure, cardiac complications, or unmanaged pain. Record review of the January 2026 eMAR for Resident #4 and interview with the Director of Nursing (DON) on 2/19/26 at 11:53 AM confirmed that the three (3) prescribed medications had not been administered as ordered. The DON further stated that facility staff did not follow the facility protocol for obtaining unavailable medications and that it was her expectation that the medications would have been obtained and administered in accordance with physician orders and facility protocol. Record review of the facility admission Record revealed that Resident #4 was admitted to the facility on [DATE] with diagnoses that included Essential Hypertension, Paroxysmal Atrial Fibrillation, and Rheumatoid Arthritis, which required ongoing physician-ordered medication management.