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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement infection control practices to prevent the spread of infection by not maintaining aseptic technique and not providing dressing changes during 3 (three) of 7 (seven) care area observations. Resident #5, Resident #23, Resident #54. Findings Include: Review of the facility policy, Infection Control with effective date of 11/01/2017 revealed, This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . Review of the facility policy titled Clean Dressing Change, dated February 2026, revealed, It is the policy of this center to provide wound care in a manner to decrease potential for infection and/or cross-contamination.9. Loosen the tape and remove the existing dressing.10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. Review of the facility Peri-Care Audit Tool, undated, revealed, .Removes soiled brief, washes front to back, changes side of cloth or disposable wipe with each swipe. STOP! Removes gloves, washes/sanitizes hands and re-gloves. RESIDENT #5 An observation on 04/21/2026 at 2:55 PM revealed Resident #5's Percutaneous Endoscopic Gastrostomy (PEG) tube site with no dressing in place and there was a yellowish-brown substance beneath and surrounding the external skin disk and extending approximately one-fourth inch to surrounding skin. Certified Nursing Assistant (CNA) #2 was present in Resident #5's room and confirmed the absence of a dressing, she confirmed the yellowish-brown substance and stated her PEG tube site looked like this often. At 3:00 PM, Licensed Practical Nurse (LPN) #5 entered Resident #5's room and confirmed that there was no dressing in place to Resident #5's PEG tube site and confirmed the presence of yellowish-brown drainage to the site. LPN #5 revealed that PEG tube site care should be completed every day and as needed for increased drainage. She also revealed that since there was no dressing to her PEG tube site and due to the amount of drainage observed to the site, there was no way to tell when the last time it was cleaned. LPN #5 confirmed that failure to keep the PEG tube site clean and dry could lead to skin irritation and infection. An interview on 04/22/26 at 10:27 AM with Assistant Director of Nursing (ADON), revealed that her expectation was for nurses to follow the physician orders when providing resident care. She revealed that PEG tube sites should be cleaned every day and should be cleaned with soap and water or normal saline, and if there was an order for a dressing to be applied, it should be done. ADON agreed that (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failure to perform daily dressing changes as ordered by the physician, along with allowing drainage to accumulate around the PEG tube sites could result in infection. An interview on 04/22/26 at 10:33 AM with Registered Nurse (RN) #1, Infection Preventionist, revealed that they expected nurses to assess PEG tube sites daily and clean around the stomas with soap and water or normal saline. She revealed that she also expected nurses to review physician orders and provide the care accordingly. RN #1 revealed that failure to clean the PEG tube sites as ordered could result in skin irritation, burning of the skin, or infection. Record review of Resident #5's admission Record revealed an original admission date of 08/07/20 and that she had diagnoses that included Alzheimer's Disease, Unspecified, Functional Quadriplegia, and Gastrostomy Status. Record review of Resident #5's Medication Administration Record with order date of 09/10/2025, revealed Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin breakdown. Record review of Resident #5's Order Summary Report revealed an order with effective date of 09/10/25 documented, Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin breakdown. RESIDENT #23 An observation and interview on 04/20/26 at 12:32 PM revealed Resident #23 lying in bed and he stated that he needed some help. He pulled his shirt up and exposed his PEG tube site which had a thick brown, crusted substance beneath the external skin disk which extended approximately one-half to three fourths of an inch to the surrounding area. Resident #23 revealed that the site had not been cleaned in approximately three days and stated, Look at this, it's nasty and I want it out. Follow-up observations on 04/21/2026 at 8:30 AM and 3:08 PM confirmed that Resident #23's PEG tube site remained unclean with visible drainage. During an interview at 3:08 PM, Resident #23 stated, I may have to clean it myself. During an observation and interview on 04/21/2026 at 3:10 PM with Licensed Practical Nurse (LPN) #5, she confirmed the presence of thick, brown drainage and stated the site had not been cleaned in several days. LPN #5 revealed that PEG tube care should be performed daily and as needed to prevent infection and skin breakdown and stated she would take care of it now. During an observation and interview on 04/21/26 at 3:25 PM with Director of Nursing, she viewed Resident #23's PEG tube site and confirmed the dry crusty brown drainage and stated that this had not been cleaned in a while. She revealed that his PEG tube site should be cleaned every day and as needed. DON also revealed that not cleaning the site daily could cause skin irritation and possible infection. She revealed that she would get the treatment nurse to look at the site and they would take care of the issue. Record review of Resident #23's Order Summary Report revealed an order dated 09/10/25, every day shift Cleanse peg tube stoma with soap and water rinse with clean water pat dry and leave open to air. Can apply dry dressing if drainage is present. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's admission Record revealed an admission date 08/14/25 with diagnoses that included Unspecified Severe Protein-Calorie Malnutrition and Gastrostomy Status. Record review of Resident #23's MDS with ARD of 01/30/2026 under Section C indicated a BIMS score of 10, reflecting moderate cognitive impairment. Resident #54 During an observation of wound care to a Stage IV pressure injury to the sacrum on 4/22/2026 at 11:10 AM with the Treatment Nurse and CNA #3, when CNA #3 opened Resident #54's brief, the presence of stool was observed. CNA #3 obtained a clean brief and wipes and provided peri-care to clean the resident prior to wound care. Immediately after completing peri-care, CNA #3 removed the existing wound dressing and assisted with repositioning the resident by rolling her so her back faced the Treatment Nurse. The Treatment Nurse then performed wound care while CNA #3 assisted in holding the resident in position using the same gloves worn during peri-care. CNA #3 did not perform hand hygiene or change gloves between peri-care and wound care. During an interview on 4/22/2026 following wound care, CNA #3 stated she should have performed hand hygiene and changed gloves after providing peri-care and prior to assisting with wound care. She stated, I just didn't bring extra gloves with me. During an interview on 4/22/2026 at 11:24 AM, the Treatment Nurse stated that CNA #3 should have performed hand hygiene after providing peri-care and confirmed that this could put the resident at risk for an infection. During an interview on 4/22/2026 at 12:14 PM, the DON and ADON confirmed hand hygiene should be performed after providing care and that CNA #3 should not have assisted with wound care without first performing hand hygiene and changing gloves. The DON stated this was an infection control concern. Record review of the admission Record indicated that the facility admitted Resident #54 on 2/24/2026 with medical diagnoses that included Chronic Diastolic (Congestive) Heart Failure and Pressure Ulcer of sacral region, stage 4. A record review of the MDS with an ARD of 4/15/26 revealed under section C, a BIMS summary score of 3 which indicated Resident #54 was severely cognitively impaired.