STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] revealed, .Purpose: To prohibit and prevent.misappropriation of resident property.Definitions.Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings.without the residents consent.A record review of the facility's Investigation Template, dated [DATE], revealed that on [DATE], 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 [DATE] 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 [DATE] revealed Resident #1 died in the facility.A record review of the Progress Notes, dated [DATE] 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 [DATE] 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 #1 that revealed the CNA was terminated on [DATE] 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 [DATE] 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 [DATE] 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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was placed on Administrative Leave on [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] with the Summary of Incident of .Following an investigation it was determined that your actions demonstrated an intent for misappropriation.On [DATE] 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 [DATE] 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 [DATE] 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 the things. CNA #4 stated she feels remorse and that she knew better. On [DATE] 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 [DATE] at 9:01 AM, during an interview with the Director of Nursing Services (DNS) she revealed that on [DATE] at 7:52 AM she received a call from the Admissions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Meridian	4728 Highway 39 North Meridian, MS 39301

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 [DATE]. 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 [DATE] 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 [DATE] 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 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 [DATE], 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 [DATE], resulting in CNAs #1, 2, 3, and 5 were interviewed and suspended on [DATE] as well as the contracted housekeeper not allowed to return to the facility. On [DATE] CNA #4 was interviewed and suspended. On [DATE], the facility contacted local police department to make a report of the incident. On [DATE] the facility made a report of the incident to the State Agency. On [DATE] 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 [DATE] 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 [DATE]. 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 [DATE], the deficient practice was determined to be Past Non-Compliance (PNC), and the facility was in regulatory compliance effective [DATE].Validation:The SA validated on [DATE], through interview and record review, that all corrective actions had been implemented as of [DATE], and the facility was in regulatory compliance on [DATE], prior to the SA's entrance on [DATE].