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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/22/2026 |
| NAME OF PROVIDER OR SUPPLIER Diversicare of Moss Point | | STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Main Street Moss Point, MS 39563 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a safe, clean, comfortable, homelike environment for residents when the facility failed to maintain resident rooms free from debris, ensure linens were clean and intact, ensure soiled items were handled in a manner that maintained a clean resident environment, and maintain clean and sanitary shower facilities, affecting three (3) of 19 sampled residents (Residents #25, #7, and #72) and all residents utilizing the North shower room. Findings include:</p> <p>A review of the facility's Resident Rights & Quality of Life Policy, dated 3/13/20, revealed, .It is the policy.that all patients and residents have the right to a dignified existence.Procedure A patient or resident has the right.To receive services in a center environment that is safe, clean, and comfortable.</p> <p>Resident #25</p> <p>On 4/19/26 at 11:45 AM, during an interview and observation with Resident #25, he reported there were times the facility failed to provide clean linens. There was a bag of odorous soiled linens resting on the floor against the wall in the resident's room. He had a clean bedspread on his bed that had a football-sized hole near the head of the bed and the mattress was exposed. Resident #25 commented that it was not unusual for bags to be on the floor and for the bedding to be damaged.</p> <p>On 4/19/26 at 11:52 AM, during an interview with Certified Nurse Aide (CNA) #1, she confirmed a bag of soiled linens was resting on the floor in Resident #25's room. She reported soiled linens should be promptly placed in a designated linen receptacle. She further reported that staff commonly left soiled linens in bags on the floor after morning care and removed them later in the day. CNA #1 confirmed that the facility had linens available without holes in the linen cart and stated that torn bedding should not be placed on resident beds.</p> <p>On 4/19/26 at 12:46 PM, during a follow-up interview with Resident #25, he reported that CNA #1 changed the bedding with the hole, but she added it to the existing bag that had been on the floor and then placed it on top of his furniture where his clean clothes were hanging.</p> <p>On 4/19/26 at 12:52 PM, during an observation and interview with Licensed Practical Nurse (LPN) #3, she confirmed the bag of soiled linens was resting on Resident #25's furniture where the resident's clean clothing was hanging and stated the placement was not appropriate.</p> <p>On 4/20/26 at 12:20 PM, during an observation and interview with Resident #25, he reported he was still upset that a bag of soiled linens that was previously on the floor was placed on top of his clean clothing yesterday. There was one (1) dead roach noted under his bed near the headboard. (continued on next page)</p> |

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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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 4/20/26 at 3:04 PM, during a follow-up interview with CNA #1, she reported she placed the bag of soiled linens on the resident's furniture to avoid dragging it across the floor and planned to return later with a soiled linen cart. She acknowledged she did not realize his clean clothing was underneath the bag and understood why he would be upset.</p> <p>A record review of the admission Record revealed the facility admitted Resident #25 on 3/13/20 with diagnoses including Type 2 Diabetes Mellitus.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.</p> <p>Resident #7</p> <p>On 4/19/26 at 12:05 PM, during an observation and interview with Resident #7, he reported housekeeping staff did not clean under the beds. There were three (3) large dead roaches under Resident #7's bed.</p> <p>On 4/20/26 at 12:27 PM, during an observation and interview with Resident #7, (3) large dead roaches continued to be observed under the bed. He reported housekeeping staff had not cleaned under his bed and stated he had not observed staff mopping or deep cleaning the room.</p> <p>On 4/21/26 at 10:39 AM, during an interview and observation with the Housekeeping Supervisor, he reported staff were expected to clean under beds during routine cleaning. There were five (5) dead roaches under Resident #7's bed. The Housekeeping Supervisor stated the area should not have been in that condition and required cleaning.</p> <p>A record review of the admission Record revealed the facility admitted Resident #7 on 3/10/25 and readmitted him on 3/31/26 with diagnoses including End Stage Renal Disease.</p> <p>A record review of the Comprehensive MDS with an ARD of 3/16/26 revealed Resident #7 had a BIMS score of five (5), which indicated the resident's cognition was severely impaired.</p> <p>Resident #72</p> <p>On 4/19/26 at 12:15 PM, during an interview with Resident #72, he reported he often picked up dead roaches himself and disposed of them because staff did not remove them. There was (1) large dead roach under his bed.</p> <p>A record review of the admission Record revealed the facility admitted Resident #72 on 10/23/25 with diagnoses including Diffuse Traumatic Brain Injury.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/26 revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of ten (10), which indicated the resident's cognition was moderately impaired.</p> <p>On 4/21/26 at 2:35 PM, during an interview with the Director of Nursing (DON), she reported it was her expectation that residents reside in a clean environment. She stated soiled linens should not be left in resident rooms or placed on residents' furniture and that the CNA should have immediately (continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>taken the dirty linen bag out of the room. She explained that torn or frayed sheets should immediately be removed and thrown out by housekeeping or removed and discarded by nursing staff. She stated they should never be applied to the residents' beds.</p> <p>North Shower Room</p> <p>On 4/20/26 at 3:00 PM, during an interview with thirteen (13) Resident Council members, three (3) residents had BIMS scores of eleven (11) and twelve (12), which indicated their cognition was moderately impaired, and ten (10) residents had BIMS scores ranging from thirteen (13) to fifteen (15), which indicated they were cognitively intact. Residents reported they refused to use the shower room due to cleanliness concerns. They reported observing dirty clothing, feces (bowel movement) and residue on shower chairs and floors.</p> <p>On 4/21/26 at 10:36 AM, during an interview with a housekeeper, she reported she cleaned the shower rooms multiple times throughout the day, however, Certified Nurse Aides (CNAs) were responsible for cleaning and sanitizing the shower room after each use. She reported observing occasions when CNAs failed to clean the shower room.</p> <p>On 4/22/26 at 9:30 AM, during an observation, the north shower room was observed with soiled clothing, including a soiled brief, on a shower chair. A yellow fluid-like substance was observed on the floor and shower chair, and a white powdery substance was observed on the floor. No staff were present at the time of observation.</p> <p>On 4/22/26 at 9:45 AM, during an interview with the Social Services Assistant, she acknowledged staff were expected to clean and sanitize the shower room after each use.</p> <p>On 4/22/26 at 10:00 AM, during an interview with the Director of Nursing (DON), she reported staff were expected to clean and sanitize the shower room after each use to ensure it was clean for the next resident.</p> <p>On 4/22/26 at 2:00 PM, during an interview with the Administrator, he confirmed staff were expected to clean and sanitize the shower room after each use and stated the shower room should not be left in an unsanitary condition.</p> | | |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to maintain an effective pest control program to prevent and control the presence of pests throughout the facility, resulting in ongoing roach activity in resident rooms and common areas for four (4) of (19) sampled residents. (Residents #25, #7, #72, and #110). Findings include: A review of the facility's policy, Pest Control, dated 9/1/2014, revealed, .It is the policy of this center to maintain an effective pest control program. Procedures.1. The center maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Resident #25 On 4/19/26 at 11:45 AM, during an observation and interview with Resident #25, two (2) gnats were observed flying in the resident's room. Resident #25 reported he observed roaches frequently in his room and stated he and his roommate continued to see roaches and flying insects despite the facility spraying for pests. On 4/20/26 at 12:20 PM, during an observation of Resident #25's room, one (1) dead roach was observed under the bed near the headboard. A record review of the admission Record revealed the facility admitted Resident #25 on 3/13/20 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of (14), which indicated the resident was cognitively intact. Resident #7 On 4/19/26 at 12:05 PM, during an observation and interview with Resident #7, three (3) large dead roaches were observed under the resident's bed. Resident #7 reported he and his roommate observed roaches regularly in the room, particularly at night, and stated roaches had been seen crawling on the ceiling and had fallen onto him and his roommate. He reported staff had been notified; however, he had not observed staff responding to assess or treat the issue. On 4/20/26 at 12:27 PM, during an observation and interview with Resident #7, (3) large dead roaches continued to be observed under the bed. Resident #7 reported an incident in which an emergency medical technician (EMT) observed roaches crawling from under the bed and expressed concern regarding the condition. A record review of the admission Record revealed the facility admitted Resident #7 on 3/10/25 and readmitted on [DATE] with diagnoses including End Stage Renal Disease. A record review of the comprehensive MDS with an ARD of 3/16/26 revealed Resident #7 had a BIMS score of five (5), which indicated the resident's cognition was severely impaired. Resident #72 On 4/19/26 at 12:15 PM, during an observation and interview with Resident #72, one (1) large dead roach was observed under the resident's bed. Resident #72 reported he had observed roaches crawling on the ceiling and under the bed and stated he often removed dead roaches himself because staff did not. A record review of the admission Record revealed the facility admitted Resident #72 on 10/23/25 with diagnoses including Diffuse Traumatic Brain Injury. A record review of the quarterly MDS with an ARD of 1/29/26 revealed Resident #72 had a BIMS score of ten (10), which indicated the resident's cognition was moderately impaired. Resident #110 On 4/21/26 at 4:30 PM, during an interview with the family member of Resident #110, she reported she felt it was necessary to bring her own roach spray to the facility due to concerns about roaches in the resident's room. She stated she was told she could not keep the spray in the room and expressed concern that the roach problem needed to be addressed. A record review of the admission Record revealed the facility admitted Resident #110 on 4/3/26 with diagnoses including Metabolic Encephalopathy. A record review of the comprehensive MDS with an ARD of 4/9/26 revealed Resident #110 had a BIMS score of eight (8), which indicated the resident's cognition was moderately impaired. On 4/20/26 at 3:00 PM, during an observation and interview with thirteen (13) Resident Council members, two (2) large roaches were observed crawling across the floor. Three (3) residents had BIMS scores of eleven (11) and twelve (12), which indicated their cognition was moderately impaired, and ten (10) residents had BIMS scores ranging from thirteen (13) to fifteen (15), which indicated they were cognitively intact. The resident's reported roaches were commonly observed in resident rooms and common (continued on next page)</p> | | |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>areas, and stated roaches were seen crawling on walls, ceilings, and floors, particularly at night. On 4/20/26 at 3:50 PM, during a phone interview with contracted pest control staff, he reported he provides pest control services monthly, focusing on different areas of the facility during each visit. He reported receiving occasional complaints of roaches but not frequently and stated he primarily treats entry points and exterior areas. He reported he had not personally observed roaches in the facility. On 4/21/26 at 10:39 AM, during an interview with the housekeeping supervisor, he reported staff are expected to notify maintenance when pests are observed so pest control services can be requested. On 4/21/26 at 2:35 PM, during an interview with the Director of Nursing (DON), she reported it was her expectation that residents reside in a sanitary environment free from pests and that staff should report pest concerns for follow-up. On 4/22/26 at 11:50 AM, during an interview with the Maintenance Director, he reported the facility utilizes a contracted pest control service monthly and as needed. He stated staff can submit maintenance requests through an electronic system for pest concerns and reported he also treats rooms when notified. He confirmed pest control services address both interior and exterior areas of the facility.</p> | | |