STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Moss Point	3401 Main Street Moss Point, MS 39563

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to ensure dishes were properly air-dried prior to use when dishware with visible moisture was used during meal service, including (10) plate dome covers and five (5) serving bowls for one (1) of two (2) kitchen observations. Findings include:A review of the facility's policy, Warewashing, revised 2/2023, revealed, .All dishware, service ware, and utensils will be cleaned and sanitized after each use. Procedures.4. All dishware will be air dried and properly stored.On 4/21/26 at 11:30 AM, during an interview and observation of tray preparation for the [NAME] Wing, the Dietary Manager was observed assisting the cook with preparing lunch trays. Plate dome covers were on a table behind the tray line with visible moisture and water dripping from the surfaces. (10) dome covers were observed to be wet. The Dietary Manager and District Dietary Manager were present during the observation and acknowledged the dome covers were wet but continued preparing trays and using the wet dome covers. During the same observation, a staff member brought five (5) serving bowls that were wet with water dripping from them, and the Dietary Manager used the bowls for tray preparation. At 11:55 AM, the last tray was removed for temperature testing, and water droplets were observed on the dome cover of the sample tray.On 4/22/26 at 1:30 PM, during an interview with the Dietary Manager, she confirmed that on 4/21/26 the plate dome covers and serving bowls used during tray preparation were wet, with water dripping from the items, and that staff used those items while preparing trays. She reported this practice is referred to as wet nesting and stated staff are expected to allow dishware to dry completely before stacking or use. She explained failure to properly clean and dry dishware and wet nesting could allow bacteria to grow and potentially cause foodborne illness.On 4/22/26 at 2:10 PM, during an interview with Registered Nurse (RN) #6, Infection Preventionist, she reported the facility had not experienced recent foodborne illness. When informed that dishware was observed to be wet during use, she explained this practice could allow bacterial growth and increase the risk of foodborne illness.On 4/22/26 at 4:46 PM, during an interview with the Administrator, he reported staff are expected to ensure all dishware is properly dried prior to stacking and use. He explained wet nesting can promote bacterial growth and increase the risk of foodborne illness. He further reported there is adequate space in the kitchen to allow proper drying and stated this issue had been previously identified and staff had been instructed to ensure dishware is fully dried before use.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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: 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. Resident #25 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. 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. 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. 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. 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. 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. A record review of the admission Record revealed the facility admitted Resident #25 on 3/13/20 with diagnoses including Type 2 Diabetes Mellitus. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Resident #7 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. 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. 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. 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. 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 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. 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 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. 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 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. North Shower Room 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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview and record review, the facility failed to ensure an ongoing program of activities designed to meet the interests and preferences of one (1) of two (2) residents reviewed for activities. Resident #70, when the facility failed to ensure weekend activities were implemented, monitored, and reflective of the resident's expressed interests.Findings include:A record review of the admission Record revealed the facility originally admitted Resident #70 on 01/09/2017 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side. He was readmitted by the facility on 7/3/2021.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. The MDS further revealed the resident reported multiple activity preferences as very important, including listening to music, participating in group activities, engaging in favorite activities, going outside, and participating in religious services.A record review of the Activity Participation Review - V3 dated 02/19/26 revealed under Attendance and Participation Summary that Resident #70 participated in Small Group and Large Group activities with frequency documented as VARIES, and under Independently, Individual activities were documented as DAILY, while participation with Family/friends and With other residents was documented as VARIES. The record further revealed under Describe resident's favorite activities, special accomplishments, new interests: that the categories Cognitive (trivia, discussion, reading, word puzzles), Entertainment (television, music, movies, visiting groups), Games (board games, bingo, cards, video games, tablets), and Spiritual (church, readings, nature, music, meditation, etc.) were selected, with Games further specified as BINGO, while Entertainment, Spiritual, and Social were documented as VARIES. A continued review revealed under Activity Plan Review that Goals were not met and have been revised. See care plan, and Interventions/approaches have not been effective in attaining goals. New approaches have been added to the care plan.A record review of the facility's activity calendar for April 2026 revealed scheduled activities throughout the week, including weekend entries such as Puzzles, Word Search, Coloring, and Watch TV in Resident Room. The calendar reflected that activities were planned for Saturdays and Sundays; however, the listed weekend activities were limited in variety and did not demonstrate individualized or structured programming specific to Resident #70's interests.On 04/19/26 at 12:50 PM, during an interview with Resident #70, he reported there were no activities for men on Saturdays and no activities on Sundays. He explained that on Saturdays there may be manicures, but nothing of interest to him. He stated he typically stayed in his room, went into the hallway, or went to the kitchen, and stated there was a need for more activities.On 04/20/26 at 12:30 PM, during an interview with the Activities Director (AD), she reported the Activities Department provided activities Monday through Friday and that activity staff did not work on Sundays. She stated that on Saturdays, activity staff may be present but are primarily assigned to transportation duties from 5:00 AM to 5:00 PM, with additional responsibilities in the dining room. She reported board games and puzzles were available in the dining room and that a movie may be left for staff to play. She stated that if a church group visited on Sunday, that would serve as an activity. The AD confirmed there was no system in place to monitor whether weekend activities occurred.On 04/20/26 at 2:00 PM, during an interview with Restorative Certified Nurse Aide (RCNA) #5, she reported the Restorative Department did not provide activity services on weekends and had not been assigned to do so. She explained her duties remained consistent seven (7) days a week and involved restorative care and dining assistance.On 04/20/26 at 3:20 PM, during an interview with Licensed Practical Nurse (LPN) #7, Director of Care Coordination, she confirmed the RCNAs were fully assigned to restorative duties and did not have time to provide activities.On 04/22/26 at 3:25 PM, during an interview with the Director of Nursing Services (DNS), she confirmed the RCNAs were not assigned to provide activities and would not have time to do so.On 04/22/26 at 5:12 PM, during an interview with (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Administrator, he acknowledged that activities were not consistently provided on weekends and stated the facility planned to implement a process to ensure activities were provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, record review, and facility policy review, the facility failed to ensure meals were served with an acceptable flavor, palatability, and appearance for two (2) of four (4) meal observations, with the potential to affect all residents receiving meals in the facility. (4/20/26 and 4/21/26)Findings include:A review of the facility's policy, Food: Quality and Palatability, dated 2/2023, revealed .Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperatures .On 4/20/26 at 11:30 AM, during an observation of lunch meal tray for Resident #48, the resident asked the surveyor to touch a grilled cheese sandwich because she could not eat it. The sandwich was hard and the cheese was not melted. A bowl containing a thick red substance identified as tomato soup was present. Resident #48 reported she could not eat the meal due to its condition.On 4/20/26 at 3:00 PM, during an interview with thirteen (13) Resident Council members, three (3) residents had Brief Interview for Mental Status (BIMS) scores of (11) and (12), which indicated their cognition was moderately impaired, and (10) residents had BIMS scores ranging from (13) to (15), which indicated they were cognitively intact The residents reported that the food was not palatable and explained they had voiced concerns about food quality during monthly food committee meetings. Residents reported they used their personal funds to purchase snacks instead of eating facility meals.On 4/21/26 at 12:13 PM, during an observation of a test lunch meal tray, the green beans were salty, and the meatballs lacked taste, were not formed, and appeared as loose ground meat in gravy. On 4/21/26 at 12:30 PM, during an interview with the Dietary Manager for facility meal services, the Dietary Manager reported she was not aware residents had complained about the food recently and she was not aware of concerns regarding food palatability.On 4/21/26 at 1:00 PM, during an interview with the Activity Director for facility residents, the Activity Director reported residents complained about food being not palatable and reported residents expressed concerns regarding taste, salt content, and food texture.On 4/22/26 at 9:10 AM, during an interview with the Social Services Director (SSD) for facility residents, the SSD reported she attended monthly food committee meetings and reported residents complained about food taste and temperature. The SSD reported the Dietary Manager documented the meeting minutes and confirmed the minutes did not reflect resident complaints.On 4/22/26 at 2:00 PM, during an interview with the Administrator regarding facility meal services, the Administrator reported he observed a thick tomato soup on 4/19/26 and reported he relied on the Dietary Manager to address food-related concerns and reported he would become involved in food committee meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection for two (2) of four (4) survey days when, on 4/21/26, staff failed to utilize appropriate Personal Protective Equipment (PPE) during high-contact resident care for a resident on Enhanced Barrier Precautions and on 4/19/26, the facility failed to ensure a nurse did not carry uncovered medications and water into one resident's room, contact the resident and the resident's environment, and then administer the same medications to another resident without performing hand hygiene.Findings include: A review of the facility's policy, Infection Control Guide, dated 2025, revealed, .Enhanced Barrier Precautions (EBP).refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug resistant organisms) to staff hands and clothing.The use of gown and gloves for high-contact resident care activities is indicated.for nursing home residents with wounds and/or indwelling medical devices. A review of the facility's policy, Policies and Practices – Infection Control, dated 11/1/2017, 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. Enhanced Barrier Precautions: On 4/21/26 at 11:00 AM, during an observation and interview for Resident #89, three (3) Certified Nurse Aides (CNAs) were observed in the resident's room. All CNAs used hand sanitizer and applied gloves; however, no gowns were worn while providing care. Catheter care was completed by CNA #4 with assistance from CNA #2 and CNA #3. During an interview, all three (3) CNAs confirmed Resident #89 was on Enhanced Barrier Precautions due to a wound and indwelling catheter and acknowledged gowns were not worn while providing care. The CNAs reported they had been educated on Enhanced Barrier Precautions and denied any shortage of PPE. Enhanced Barrier Precaution signage was observed on the resident's door. On 4/21/26 at 4:10 PM, during an interview with the Director of Nursing (DON), she reported she expected all staff to wear appropriate PPE when providing care to residents on Enhanced Barrier Precautions. She stated staff had received repeated education and in-services on PPE use and confirmed PPE was readily available on each unit. On 4/22/26 at 2:06 PM, during an interview with Registered Nurse (RN) #5, Infection Preventionist, she reported Enhanced Barrier Precautions are required for residents with wounds, catheters, or PEG tubes during high-contact care activities. She stated PPE is expected to be worn during care and confirmed staff had received repeated education on these requirements. A record review of the admission Record revealed the facility admitted Resident #89 on 2/2/26 with diagnoses including End Stage Renal Disease. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/26 revealed Resident #89 had a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident's cognition was severely impaired. A review of Section H revealed Resident #89 had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Order Summary Report revealed Resident #89 had a physician's order, dated 2/4/26, for a Foley (indwelling catheter) for neurogenic bladder. Hand Hygiene: On 4/19/26 at 12:42 PM, during an observation, Licensed Practical Nurse (LPN) #6 entered an unsampled resident's room carrying an uncovered cup containing medications and an uncovered cup of water intended for another resident. While in the room, LPN #6 used her free hand to adjust the resident's nasal cannula and reposition the resident in bed. LPN #6 then exited the room carrying the same uncovered medications and water, proceeded to another resident's room, and administered the medications without performing hand hygiene. On 4/19/26 at 2:55 PM, during an interview with LPN #6, she acknowledged she should not have taken medications intended for one resident into another resident's room and confirmed she failed to perform hand hygiene. She reported she believed hand hygiene was only required after every third (3rd) resident. She acknowledged this practice could result in contamination of medications and the potential spread of germs between residents. On 4/21/26 at 12:09 PM, during an interview with the Director of Nursing Services (DNS), she confirmed medications should be taken directly to the intended resident and stated staff are expected to perform hand hygiene after contact with a resident or the resident's environment. She reported carrying uncovered medications into another resident's room created a risk of contamination and potential transmission of infection.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **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 #25On 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 intactResident #7On 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 #72On 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 #110On 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)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Moss Point	3401 Main Street Moss Point, MS 39563

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a Foley (indwelling catheter) securement device was in place to prevent tension and pulling on the catheter for one (1) of (1) resident reviewed for catheters. Resident #89.Findings include:A review of the facility's document, Proper Techniques for Urinary Catheter Maintenance, undated, revealed, .Maintain unobstructed urine flow. Keep the catheter and collecting tube free from kinking.On 4/20/26 at 12:15 PM, during an observation and interview, Resident #89 was observed sitting in a wheelchair in the hallway with catheter tubing visible. The resident was wearing shorts, and no catheter securement device was observed in place. During an interview, the resident reported he did not have anything to hold the catheter in place.On 4/21/26 at 11:00 AM, during an observation of catheter care with Certified Nurse Aide (CNA) #4, assisted by CNA #2 and CNA #3, no catheter securement device was observed in place for Resident #89. Following care, during an interview with all three (3) CNAs, they confirmed there was no catheter securement device in place. CNA #3 reported the nurse must apply the catheter securement devices and that they were locked in the central supply closet. CNA #4 reported the resident had not had a securement device in place all morning and that she had notified the nurse.On 4/21/26 at 11:25 AM, during an interview with Registered Nurse (RN) #4, she reported residents with indwelling catheters are required to have a securement device in place at all times to prevent tension, pulling, and complications.On 4/21/26 at 3:00 PM, during an interview and observation with Licensed Practical Nurse (LPN) #1, she reported that she had not been informed that a catheter securement device was needed for Resident #89. During an observation of the resident, there was no catheter securement device present. She explained the purpose of the device is to prevent pulling and trauma.On 4/21/25 at 4:10 PM, during an interview with the Director of Nursing (DON), she reported all residents with indwelling catheters are expected to have a securement device in place to prevent trauma or pulling. She confirmed staff are expected to notify nursing immediately if a device is not in place so it can be reapplied.A record review of the admission Record revealed the facility admitted Resident #89 on 2/2/26 with current diagnoses including Osteomyelitis of Vertebra.A record review of the Order Summary Report revealed Resident #89 had a Physician's Order, dated 2/4/26, for a foley catheter for neurogenic bladder.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/26 revealed Resident #89 had a Brief Interview for Mental Status Score of seven (7) which indicated his cognition was severely impaired. A review of Section H revealed he had an indwelling catheter.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure a resident receiving enteral nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube received care and services to prevent complications when the tube feeding solution, water flush bag, and syringes were not labeled for one (1) of (1) residents reviewed for enteral feeding. Resident #90.Findings include:On 4/19/26 at 1:10 PM, during an observation, Resident #90 was observed lying in bed with the head of the bed elevated. A tube feeding was observed infusing at (55) milliliters (ml) per hour via a feeding pump. The feeding bag contained formula; however, the bag was not labeled with the type of feeding, date, time, or rate. A water flush bag was observed labeled with the resident's name and date of 4/19/26; however, no time or additional information was noted. Two (2) syringes were observed in the room, one (1) on the bed near the pillow and (1) on the bedside table; however, neither syringe was labeled or dated.On 4/19/26 at 3:05 PM, during an observation and interview with Certified Nurse Aide (CNA) #3, she confirmed the feeding bag contained formula and was not labeled. She reported the resident received tube feeding only and did not receive anything by mouth.On 4/19/26 at 3:16 PM, during an observation and interview with Licensed Practical Nurse (LPN) #4, she reported she had hung the tube feeding earlier that day and confirmed the feeding bag was not labeled with the type of feeding, date, time, or rate. She stated there was (1) label available, which she applied to the water flush bag. She confirmed the resident had (2) syringes used for care and acknowledged neither syringe was labeled or dated. She explained night shift typically replaces syringes daily; however, all syringes are expected to be labeled and dated.On 4/21/26 at 4:48 PM, during an interview with the Director of Nursing (DON), she confirmed all tube feeding solutions and supplies should be labeled with the resident's name, date, time, and rate. She reported the facility uses both prefilled feeding bottles and pourable feeding bags and stated she would expect any feeding bag in use to be labeled appropriately. She further confirmed syringes should be labeled and dated to prevent potential complications. She reported the facility did not have a policy specific to PEG feeding labeling and only had a competency skills checklist, which did not address labeling.A record review of the admission Record revealed the facility admitted Resident #90 on 1/20/26 with diagnoses including Unspecified Severe Protein-Calorie Malnutrition and Dysphagia, Unspecified.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/26 revealed Resident #90 required staff assessment for mental status and had severely impaired cognitive skills for daily decision making. A review of Section K revealed the resident had a feeding tube.A record review of the Order Summary Report revealed Resident #90 had a Physician's Order with a start date of 1/20/26 for Nothing by mouth (NPO) status and an enteral feeding order dated 2/11/26 for Formula Jevity 1.5 at 55 (ml)per hour.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of less than five percent (5%) when two (2) medications were prepared to be administered without appropriate clinical assessment during medication administration. Resident #110, resulting in two (2) errors out of (27) opportunities, with a medication error rate of 7.41%.Findings include:A review of the facility's policy, Medication Administration, dated 07/23, revealed, .All medications are administered as prescribed, in accordance with good nursing principles and practices.Personnel authorized to administer medications do so only after they have familiarized themselves with the medications.Procedure.Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition.the physician is contacted for clarification prior to the administration of the medication.On 4/21/26 at 7:55 AM, during an observation of morning medication administration, Licensed Practical Nurse (LPN) #1 was observed preparing medications for Resident #110, including Entresto (Sacubitril-Valsartan) 24-26 milligrams (mg) and Metoprolol 100 milligrams (mg), and placing them into a medication cup with the resident's scheduled medications. During the observation, Certified Nurse Aide (CNA) #2 informed LPN #1 that Resident #110's blood pressure was low. LPN #1 reviewed the electronic record and identified the resident's blood pressure as 88/56. LPN #1 then secured the medication cart and proceeded toward the resident's room with the prepared medications. During questioning, LPN #1 confirmed she intended to administer the medications and stated she did not have parameters to hold them. She removed the Metoprolol and Entresto after being questioned regarding the affect the medications would have on the resident's blood pressure.On 4/21/26 at 9:28 AM, during an interview with LPN #1, she reported it is the nurse's responsibility to assess a resident when a low blood pressure is reported and confirmed she would have administered both medications if the concern had not been raised.On 4/21/26 at 2:33 PM, during an interview with the Director of Nursing (DON), she reported nurses are expected to assess residents and hold medications when appropriate and to notify the physician when a resident presents with low blood pressure prior to administering medications that could further lower it.On 4/21/26 at 3:10 PM, during an interview with the pharmacist, she reported nursing staff are expected to use clinical judgment and contact the physician when blood pressure is low prior to administering antihypertensive medications. She confirmed both Metoprolol and Entresto have the potential to lower blood pressure.On 4/22/26 at 3:12 PM, during a follow-up interview with the DON, she reported the Entresto order included a parameter to hold the medication if systolic blood pressure was less than 100. She confirmed the nurse did not identify this parameter and stated she understand the medication error rate standard was five percent (5%).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 Order Summary Report revealed Resident #110 had a Physician's Orders, dated 4/3/26, for Metoprolol Tartrate, one (1) tablet by mouth two times daily, and Sacubitril-Valsartan (Entresto), one (1) tablet by mouth two times daily, with instructions to hold for systolic blood pressure less than 100.A record review of the Weights and Vital Summary revealed Resident #110 had a documented blood pressure of 88/56 on 4/21/26 at 7:58 AM.A record review of the Metoprolol: Package Insert/Prescribing Information, updated 6/16/25, revealed, .Metoprolol tartrate is a beta-adrenergic blocker indicated for the treatment of hypertension.Contraindications.systolic blood pressure <100.A record review of the Highlights of Prescribing Information, revised 4/2024, revealed, .Entresto.contains valsartan.Warnings and Precautions.Hypotension.Entresto lowers blood pressure and may cause symptomatic hypotension.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were administered safely, resulting in significant medication errors when staff prepared to administer antihypertensive medications to a resident with a blood pressure of 88/56 without appropriate assessment or adherence to hold parameters (Resident #110) and failed to administer ordered antibiotic therapy as prescribed (Resident #69) for two (2) of six (6) residents reviewed for medication administration.Findings include: A review of the facility's policy, Medication Administration, dated 07/23, revealed, .All medications are administered as prescribed, in accordance with good nursing principles and practices.Personnel authorized to administer medications do so only after they have familiarized themselves with the medications.Procedure.Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition.the physician is contacted for clarification prior to the administration of the medication.If a dose of an ordered medication is needed but the nurse is unable to locate at the time of administration, the nurse should call the pharmacy for further instruction. Resident #110 During an interview and observation of medication administration on 4/21/26 at 7:55 AM, Licensed Practical Nurse (LPN) #1 prepared Resident #110's morning medications, including Entresto (Sacubitril-Valsartan) 24-26 milligrams (mg) and Metoprolol 100 milligrams (mg). LPN #1 placed the resident's medication into a cup. At that time, Certified Nurse Aide (CNA) #2 reported that Resident #110's blood pressure was low. LPN #1 reviewed the electronic record and stated the blood pressure as 88/56. LPN #1 then secured the medication cart and proceeded toward the resident's room with the prepared medications. During questioning, she confirmed she intended to administer the blood pressure medications and stated she did not have parameters to hold them. After questioning the safety of giving blood pressure medications to a resident with low pressure occurred, LPN #1 then removed Metoprolol from the medication cup and discarded it. After further questioning specifically about Entresto, which also lowers blood pressure, she acknowledged the concern and removed and discarded that medication prior to administering the remaining medications. During an interview on 4/21/26 at 9:28 AM, LPN #1 reported it is the nurse's responsibility to assess a resident when a low blood pressure is identified and confirmed she would have administered both medications if the concern had not been raised. On 4/21/26 at 10:35 AM, during an interview with CNA #2, she confirmed the resident's blood pressure readings were 87/58 and 88/56 and that she reported the readings to nursing staff. On 4/21/26 at 1:44 PM, during an interview with Nurse Practitioner (NP) #1, he reported the resident typically has low blood pressure and stated that administration of these medications could have caused the blood pressure to drop to an unsafe level. He reported the expectation that nursing staff notify the provider when abnormal vital signs are identified. During an interview on 4/21/26 at 2:33 PM, the Director of Nursing (DON), she reported nurses are expected to assess residents, hold medications when appropriate, and notify the provider when blood pressure is low prior to administering medications that may further decrease blood pressure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/26 at 3:10 PM, during an interview with the pharmacist, she reported both Metoprolol and Entresto have the potential to lower blood pressure and confirmed staff are expected to use clinical judgment and notify the provider when blood pressure is low prior to administration. During a follow-up interview with the DON on 4/22/26 at 3:12 PM, she confirmed the Entresto order included a parameter to hold the medication if systolic blood pressure was less than 100 and stated the nurse failed to identify and follow this parameter. 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 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/9/26 revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. A record review of the Order Summary Report with active orders as of 4/21/26, revealed Resident #110 had Physician's Orders, dated 4/3/26, for Metoprolol Tartrate, one (1) tablet by mouth two times daily, and Sacubitril-Valsartan (Entresto), one (1) tablet by mouth two times daily, with instructions to hold for systolic blood pressure less than 100. A record review of the Weights and Vital Summary revealed Resident #110 had a documented blood pressure of 88/56 on 4/21/26 at 7:58 AM. A record review of the Metoprolol: Package Insert/Prescribing Information, updated 6/16/25, revealed, .Metoprolol tartrate is a beta-adrenergic blocker indicated for the treatment of hypertension.Contraindications.systolic blood pressure <100. A record review of the Highlights of Prescribing Information, revised 4/2024, revealed, .Entresto.contains valsartan.Warnings and Precautions.Hypotension.Entresto lowers blood pressure and may cause symptomatic hypotension. Resident #69 A record review of the Order Summary Report revealed Resident #69 had a Physician's Order, dated 4/1/26, for Vancomycin HCl Oral Suspension 50 milligrams (mg) per milliliter (ml), to administer 2.5 ml by mouth every six (6) hours for Clostridium difficile (c-diff) for seven (7) days, with an end date of 4/8/26. A record review of the Medication Administration Record (MAR) for April 2026 revealed Resident #69 had two (2) doses coded with a 7, indicating Other/See Progress Notes, including the 6:00 PM dose on 4/1/26 and the 12:00 AM dose on 4/2/26. A record review of the progress notes for Resident #69 revealed entries dated 4/1/26 at 8:43 PM and 4/2/26 at 12:00 AM documenting medication on order. A record review of the facility's Packing Slip revealed the Vancomycin for Resident #69 was delivered on 4/2/26 at 1:56 AM. On 4/21/26 at 11:10 AM, during an interview with Registered Nurse (RN) #4, she confirmed the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vancomycin for Resident #69 was not administered due to unavailability and reported she documented medication on order. She acknowledged she did not notify supervisory staff of the missed doses. On 4/21/26 at 2:00 PM, during an interview with NP #1, he reported failure to complete a full course of antibiotic therapy could result in continued or recurrent infection. On 4/21/26 at 3:10 PM, during an interview with the consultant pharmacist, she reported the facility has access to emergency medication supplies and pharmacy resources and stated staff are expected to obtain medications through alternative means and not leave doses unadministered. On 4/21/26 at 5:15 PM, during a phone interview with RN #5, she confirmed she was aware the Vancomycin for Resident #69 was not available and that it was delivered after midnight; however, the scheduled dose was not administered, and supervisory staff were not notified. On 4/22/26 at 3:25 PM, during an interview with the DON, she reported staff are expected to notify appropriate personnel when medications are unavailable and confirmed she was not aware Resident #69 had missed doses until identified during the survey. A record review of the admission Record revealed the facility admitted Resident #69 on 4/1/26 with diagnoses including Enterocolitis due to Clostridium difficile, recurrent. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/26 revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. A review of Section N revealed the resident received antibiotic therapy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure accurate and complete medical records when nursing staff failed to document accurately on administration records for one (1) of (19) sampled residents. Resident #14.Findings include:A review of the facility's Purpose of the Patient Record revealed, .Process: Clinical records are maintained to provide complete and accurate patient information for continuity of care. The record shall contain sufficient information to identify the patient clearly, justify the diagnosis and treatment, and document results accurately.A record review of the admission Record revealed the facility admitted Resident #14 on 3/30/22 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/26 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident's cognition was severely impaired.A record review of the Order Summary Report revealed Resident #14 had a Physician's Order, dated 2/2/26, for wound care to the sacral pressure ulcer.A record review of the Treatment Administration Record (TAR) for March 2026 revealed Resident #14 had no nurse signature or documentation to indicate wound care was completed to the sacral pressure ulcer on 3/2/26, 3/4/26, 3/5/26, 3/6/26, 3/14/26, 3/15/26, 3/20/26, 3/24/26, 3/25/26, 3/26/26, and 3/30/26. A continued record review of the Treatment Administration Record (TAR) for April 2026 revealed Resident #1 had no nurse signature or documentation to indicate wound care was completed to the sacral pressure ulcer on 4/11/26 and 4/12/26.On 4/22/26 at 12:30 PM, during an interview with the Director of Nursing (DON), she acknowledged there were multiple blank entries on the TAR for Resident #14 and reported nurses were completing wound care but not documenting it. She stated documentation was expected at the time care was provided and acknowledged that if care was not documented, it could not be verified as completed.On 4/22/26 at 1:30 PM, during an interview with Registered Nurse (RN) #1, she acknowledged she did not always document wound care for Resident #14 on the TAR after completing treatments and reported she was responsible for ensuring documentation was completed.On 4/22/26 at 2:00 PM, during an interview with the Administrator, he reported staff were expected to document treatments for Resident #14 after providing care.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to follow infection control practices by not implementing Enhanced Barrier Precautions (EBP) for a resident at high risk for Multidrug Resistant Organisms (MDRO) during an annual recertification survey on 12/05/2024 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of (12) deficiencies cited. F880. Findings Include:Review of the facility's policy, Quality Assessment and Performance Improvement (QAPI), dated March 2025, revealed, .The center develops, implements, and maintains an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care.Procedure.3. The QAPI plan will address the following elements:.c.addressing how the committee will conduct activities necessary to identify and correct quality deficiencies.i. Tracking and measuring performance. ii. Establishing goals and thresholds for performance improvements. Iii. Identifying and prioritizing quality deficiencies. iv. Systematically analyzing underlying causes of systemic quality deficiencies. v. Developing and implementing corrective action or performance improvement activities. vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.Record review of the Provider History Report revealed the facility received a citation during the annual recertification survey for F880-Infection Prevention & Control.Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 12/05/2024, revealed the facility received a citation for F880, .Based on observation, staff interviews, record reviews, and facility policy reviews, the facility failed to follow infection control practices by not implementing Enhanced Barrier Precautions (EBP) for a resident at high risk for Multidrug-Resistant Organisms (MDRO) for one (1) of 21 sampled residents.During the current recertification survey, the facility failed to prevent the possible spread of infection when on 4/21/26, staff failed to utilize appropriate Personal Protective Equipment (PPE) during high-contact resident care for a resident EBP.On 04/22/2026 at 5:15 PM, during an interview with the Administrator, he stated that in response to the previous citation the QAPI team developed a plan of correction that was ongoing for (13) weeks to ensure EBP procedures and carried out correctly. The Administrator stated that the plan was implemented by all staff and was monitored by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), and the Director of Clinical Education (DCE). The Administrator stated that the QAPI committee revisited this citation monthly for three (3) months and that a spreadsheet was developed to track their monitoring and findings. The Administrator revealed that no relapses occurred during the facility's monitoring period. The Administrator stated this indicated that the monitoring should have been hard wired at that time. The Administrator revealed that ongoing processes to ensure improvements will include management walking around and monitoring staff in daily work, annual training on EBP, and monitoring for infections.