STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Quitman	191 Highway 511 East Quitman, MS 39355

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure residents and their resident representatives (RRs) received written notice of hospital transfers, including the reason for the transfer, in a language and manner they could understand for three (3) of four (4) residents reviewed for discharges and hospitalization. Resident #1, Resident #3, and Resident #98. Findings include:A review of the facility's policy, Transfer and Discharge, dated 11/1/2016, revealed, .(Proper Name of Facility) shall permit each Resident to remain at the Center, and not transfer or discharge the Resident from the Center except in accordance with Federal and State laws.Procedure.Notice Requirements 4. Before (Proper Name of Facility) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the or discharge in a language and manner they understand.5.Notice may be made as soon as practicable before a transfer or discharge when.An immediate transfer is required by the Resident's urgent medical needs.Resident #1A record review of the admission Record revealed the facility admitted Resident #1 on 3/20/2026 with current diagnoses including Diabetes Mellitus.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.A record review of the Progress Notes revealed Resident #1 was transferred to the hospital on 2/12/26, 3/15/26, 4/10/26, 4/19/26, and 5/10/26. A review of Resident #1's medical record revealed there was no documentation indicating the resident or the RR received written notification of the transfers that occurred on 2/12/26, 3/15/26, 4/10/26, 4/18/26, and 5/10/26.On 5/20/26 at 8:00 AM, during an interview with the RR for Resident #1, she reported she received telephone notification regarding the hospital transfers but did not receive written notification explaining the reason for the transfers.Resident #3A record review of the admission Record for revealed the facility admitted Resident #3 on 1/15/26 and she had current diagnoses including Diabetes Mellitus.A record review of the Quarterly MDS with an ARD of 4/22/26 revealed Resident #3 had a BIMS score of 15, which indicated the resident was cognitively intact.A record review of the Progress Notes revealed Resident #3 was transferred to the hospital on [DATE], 12/19/25, and 12/25/25.A review of Resident #3's medical record revealed there was no documentation indicating the resident or the RR received written notification of the transfers that occurred on 12/1/25, 12/19/25, and 12/25/25.On 5/20/26 at 9:35 AM, during an interview with the RR for Resident #3, the representative explained that she had been notified by phone each time the resident was transferred, but she did not receive any type of written notification explaining the reason for the transfers.Resident #98A record review of the admission Record revealed the facility admitted Resident #98 on 4/1/26 and he had current diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.A record review of the Comprehensive MDS with an ARD of 4/8/26 revealed Resident #98 had a BIMS score of 9, which indicated the resident's cognition was moderately impaired.A record review of the Progress Notes revealed Resident #98 was transferred to the hospital on 5/2/26.A review of Resident #98's medical record revealed there was no documentation indicating the resident or the RR received written (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
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notification of the transfer that occurred on 5/2/26.On 5/20/26 at 8:57 AM, during an interview with the Business Office Manager (BOM), she reported she was responsible for sending bed-hold letters to families but was not responsible for sending written notifications explaining the reason residents were transferred to the hospital.On 5/20/26 at 9:29 AM, during an interview with the Social Services Director (SSD), she reported she was unaware she was responsible for sending written notifications to resident representatives explaining the reason for hospital transfers. The SSD explained she routinely sent notifications to the Ombudsman regarding hospital transfers and discharges.On 5/20/26 at 11:00 AM, during an interview with the RR for Resident #98, she stated she had not received any type of written notification explaining the reason for the resident's transfer to the hospital. She said that she was notified by phone on the day he was transferred and was told the reason for the transfer at that time. On 5/20/26 at 1:30 PM, during an interview with the Director of Nursing (DON), she reported the facility was expected to provide written notification to resident representatives when residents were transferred to the hospital. The DON confirmed there was no documentation indicating that written notifications of transfers were provided for Resident #1, Resident #3, or Resident #98.On 5/20/26 at 1:44 PM, during an interview with the Administrator, she reported staff were expected to follow the facility transfer notification policy and ensure resident representatives received written notification of hospital transfers.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to timely develop a comprehensive care plan with interventions related to an indwelling catheter placement for one (1) of (20) sampled residents reviewed for care planning. Resident #92. Findings include:A review of the facility's policy, Care Plans, dated 10/2025, revealed, .Care plans will be developed for all patients and residents.Care plans are developed by the interdisciplinary team.A record review of the Care Plan Report revealed Resident #92 had a care plan Focus of The resident has.Foley Catheter RT (related to) Obstructive Uropathy and Reflux Uropathy initiated on 5/4/26. The care plan included multiple interventions related to catheter care and monitoring, all initiated on 5/4/26.A record review of Section H of the Discharge - Return Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/21/26 revealed Resident #92 did not have an indwelling catheter when discharged from the facility to an acute care hospital.A record review of the Discharge Summary from the acute care hospital, dated 2/25/26, revealed Resident #92 had instructions for .Foley (indwelling catheter) being kept in place for discharge.A record review of the facility's Progress Note, dated 2/26/26, revealed Resident #92 returned to the facility from the acute care hospital and included, Resident with Foley catheter in place.A record review of Resident #92's medical record revealed there was no documentation of physician orders related to indwelling catheter care or monitoring from the resident's return to the facility on 2/26/26 until 5/8/26, approximately ten (10) weeks after returning to the facility.A record review of the Order Summary Report revealed Resident #92 had Physician's Orders, dated 5/4/26 for a Foley catheter.A record review of the May 2026 Treatment Administration Record revealed indwelling catheter care for Resident #92 was initiated on 5/4/26. This was the first documentation identified related to catheter care, monitoring, or placement since Resident #92 returned to the facility on 2/26/26.On 5/21/26 at 10:40 AM, during an interview with the Director of Nursing (DON), she confirmed Resident #92 did not have a Foley (indwelling catheter) prior to hospitalization and the catheter was placed during the resident's February 2026 hospital stay. The DON confirmed a care plan related to the indwelling catheter was not developed until 5/4/26 despite the resident returning to the facility on 2/26/26 with the catheter in place and it had remained in place. The DON stated her expectation was for staff to develop care plans timely.On 5/21/26 at 2:30 PM, during an interview with the Administrator, she stated her expectation was for care plans to be developed timely to reflect the resident's current condition.A record review of the admission Record revealed the facility admitted Resident #92 on 5/17/21 with diagnoses including Obstructive Uropathy and Reflux Uropathy. The record further revealed an onset date of 5/4/26 for the diagnoses.A record review of the Quarterly MDS with an ARD of 5/18/26 revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's call light remained accessible and within reach for one (1) of (20) sampled residents reviewed for call light accessibility. Resident #77.Findings include:A review of the facility's policy, Nurse Call Policy, dated 9/1/2014, revealed, .Guidelines.2. Each cord needs to be visible and reachable by the resident which it operates for.4. Any component that does not function should be repaired as soon as practically feasible.A record review of the admission Record revealed the facility admitted Resident #77 on 1/18/24 with diagnoses including Dementia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/26 revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of (13), which indicated the resident was cognitively intact.On 5/18/26 at 11:51 AM, during an observation and interview, Resident #77's call light string was observed out of the resident's reach. Resident #77 stated the string was out of reach and she would not have been able to call for assistance if needed. The call light system required the resident to pull the string to activate the call light outside the resident's room and at the nurses' station.On 5/18/26 at 12:04 PM, during an observation and interview, Certified Nursing Assistant (CNA) #1 entered Resident #77's room and picked the call light string up from the floor. The call light string did not have a clip attached to the end. CNA #1 explained the clip must have fallen off and without a clip, the call light string would not attach to the resident's clothing or bedding. CNA #1 reported the string may have fallen out of reach while she was adjusting the bed. She was unable to recall how long the clip had been missing from the call light string. There was no clip visible on the floor or near the bed.On 5/20/26 at 2:34 PM, during an interview, CNA #2 stated staff were trained to ensure residents' call lights remained within reach when exiting resident rooms and to ensure resident needs were addressed prior to leaving the room.On 5/21/26 at 11:04 AM, during an interview, the Director of Nursing (DON) stated nursing staff were responsible for reporting equipment concerns to maintenance and could submit requests through the Technology for Equipment and Life Safety (TELS) work order system in the electronic health record.On 5/21/26 at 11:35 AM, during an interview, the Housekeeping/Maintenance Director (HM) #1 stated call light systems were checked monthly, and staff could submit maintenance requests verbally or through the TELS system. HM #1 stated no maintenance request had been verbally received or received in TELS regarding repair of Resident #77's call light and explained that maintenance requests submitted through the TELS system generated immediate notifications to his cellular phone.On 5/21/26 at 2:37 PM, during an interview, the Administrator stated staff were expected to report maintenance concerns through the appropriate process and ensure Resident #77's call light clip was replaced. The Administrator stated staff should have monitored Resident #77 more frequently until the call light clip was repaired.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, record review, and facility guideline review, the facility failed to revise the comprehensive care plan to reflect Resident #29's current diabetic management orders and interventions for one (1) of (20) sampled residents reviewed for care plans. Resident #29.Findings include:A review of the facility's Care Plans guideline, dated 10/2025, revealed, .Care plans are developed.and revised as needed according to resident and patient status or change.A record review of the Care Plan Report revealed Resident #29 had a focus area for Alteration in Blood Glucose due to: Hyperglycemic Episodes, DX OF TYPE 2 DIABETES MELLITUS, initiated on 3/15/24 and revised on 6/26/24. Further review revealed interventions including ACCU Checks PRN, accuchecks bid. Notify provider if BG is less than 70 and greater than 450 mg/dL two times a day for DM, and Accuchecks PRN. Notify provider of BG 70 and >400. A comparison of the care plan interventions to the active physician orders revealed Resident #29 did not have physician orders for accuchecks as needed (PRN) or accuchecks twice daily (BID). A comparison further revealed the care plan contained conflicting blood sugar notification parameters of greater than 450 mg/dL and greater than 400; however, the active physician orders did not contain instructions regarding when nursing staff should notify the physician or nurse practitioner for abnormal blood sugar results. Further review revealed care plan interventions including ADMINISTER GLUCAGON INJECTION AS ORDERED, Glucagon HCl Injection Solution Reconstituted 1 MG (Glucagon HCl) Inject 1 mg intramuscularly as needed for hypoglycemia give if BG is less than 70 and unresponsive, and Gvoke HypoPen 1-Pack Subcutaneous Solution Auto-injector 1 MG/0.2ML (Glucagon) Inject 1 application subcutaneously as needed for Hypoglycemia / Unresponsive. A comparison of the care plan interventions to the active physician orders revealed the active physician order for Gvoke did not contain blood sugar parameters, symptom parameters, or instructions indicating the resident should be unresponsive prior to administration. A record review further revealed interventions directing staff to observe for signs and symptoms of high and low blood sugar and report signs and symptoms of advanced hypoglycemia to nursing and the physician, however there was no documentation in the medical record indicating this was being done. A record review of the Order Summary Report revealed Resident #29 had physician orders dated 3/2/26 related to Type 2 Diabetes Mellitus for NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 units/mL (Insulin Aspart) with blood sugar (BS) checks three (3) times daily, Dapagliflozin Propanediol Oral Tablet 10 milligrams (mg) daily, and Lantus Subcutaneous Solution 100 units/milliliter (mL) inject 70 units subcutaneously daily. Further review revealed Resident #29 had a physician order dated 3/2/26 for Gvoke PFS Subcutaneous Solution Prefilled Syringe 1 mg/0.2 mL (Glucagon), to inject one (1) syringe subcutaneously as needed for hypoglycemia related to Type 2 Diabetes Mellitus with Diabetic Neuropathy.A review of Resident #29's medical record revealed there was no documentation indicating staff were observing Resident #29 for signs and symptoms of high and low blood sugar and reporting signs and symptoms of advanced hypoglycemia to nursing and the physician.On 5/20/26 at 1:30 PM, during an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) and care plan nurse, she stated she was responsible for revising resident care plans. RN #1 reviewed Resident #29's care plan regarding alteration in blood glucose and the current physician orders and confirmed the care plan had not been revised to reflect the resident's current physician orders. RN #1 stated she had been reviewing resident care plans and comparing them to physician orders but had not yet reviewed Resident #29's care plan. RN #1 confirmed a nurse administering medications would not have been able to accurately follow the care plan because the care plan contained conflicting instructions.On 5/20/26 at 2:00 PM, during an interview and record review with the Director of Nursing (DON), she reviewed Resident #29's physician orders and care plan and confirmed the care plan was not accurate and had not been revised to reflect the resident's current physician orders. The DON stated the nurses would have been unable to follow the care plan because (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it contained conflicting parameters and orders that were no longer active.On 5/20/26 at 4:30 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, she stated she did not review Resident #29's care plan before, during, or after administration of glucagon on 5/19/26 because she was focused on the resident's condition and satisfied with the resident's response after the glucagon administration.A record review of the admission Record revealed the facility admitted Resident #29 on 1/19/25 with diagnoses including Diabetes Mellitus (DM).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, record review, and facility policy review, the facility failed to provide treatment and services according to professional standards of practice by failing to monitor, assess, and provide appropriate follow-up for abnormal blood sugar results, insulin holds/refusals, and glucagon administration for Resident #29 and by failing to timely implement physician orders related to indwelling catheter management for Resident #92 for two (2) of (20) sampled residents reviewed for treatment and services. Findings include: A review of the facility's policy, Medication Administration, dated 7/2023, revealed, .Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices.Procedure.When PRN medications are administered, the following documentation is provided.Complaints or symptoms for which the medication was given.If a dose of regularly scheduled medication is withheld, refused.An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. A review of the Patient Information for GVOKE injection revealed, .GVOKE is a prescription medication used: to treat very low blood sugar (severe hypoglycemia).Tell your healthcare provider each time you use GVOKE. Resident #29 A record review of the Order Summary Report revealed Resident #29 had a physician order dated 3/2/26 for NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 units/mL (Insulin Aspart) with blood sugar (BS) checks three (3) times daily. A record review further revealed Resident #29 had an order dated 3/2/26 for Gvoke PFS Subcutaneous Solution Prefilled Syringe 1 mg/0.2 mL (Glucagon), to inject one (1) syringe subcutaneously as needed for hypoglycemia related to Type 2 Diabetes Mellitus with Diabetic Neuropathy. There were no physician order parameters indicating when staff should hold the NovoLOG, notify the physician regarding abnormal blood sugar results, or administer Gvoke. A record review of the May 2026 Medication Administration Record (MAR) revealed Resident #29's NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 units/mL (Insulin Aspart) had routine scheduled insulin administration at 0600 (6:00 AM), 1100 (11:00 AM), and 1700 (5:00 PM). The MAR included chart codes explaining reasons insulin was not administered, including SS (blood sugar levels indicate no insulin needed), 2 (drug refused), 3 (hold/see progress notes), and 7 (other/see progress notes). Further review of the MAR revealed that for the 0600 administration on 5/12/26, 5/14/26, and 5/19/26, chart code SS was documented indicating no insulin was required per sliding scale coverage; however, there was no actual blood sugar result documented on the MAR. A record review of the MAR revealed that for the 0600 administration on 5/15/26 and 5/18/26, chart code 2 was documented indicating the resident refused the medication. A record review of the MAR revealed that for the 1100 administration on 5/3/26, chart code SS was documented indicating no insulin coverage was required. A record review of the MAR revealed that for the 1100 administration on 5/10/26, 5/12/26, and 5/17/26, chart code 2 was documented indicating the resident refused the medication. A record review of the MAR revealed that for the 1100 administration on 5/11/26, chart code 3 was documented indicating the medication was held and to see progress notes. A record review of the MAR revealed that for the 1100 administration on 5/14/26, chart code 7 was documented indicating to see progress notes. A record review of the MAR revealed that for the 1700 administration on 5/12/26 and 5/16/26, chart code 2 was documented indicating the resident refused (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication. A record review of the MAR further revealed one (1) documented administration of PRN Gvoke solution on 5/19/26 at 6:05 AM. A record review of the progress notes and Orders - Administration Note documentation revealed there was no nursing note on 5/3/26 explaining why Resident #29's NovoLOG was not administered at the 1100 scheduled administration time. A record review of the Orders - Administration Note dated 5/10/26 at 11:15 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29 refused the medication, no documentation of education provided to the resident regarding negative outcomes of refusal, and no documentation indicating physician notification. A record review of the Orders - Administration Note dated 5/11/26 at 10:50 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness held BG 54. There was no documentation indicating Resident #29's signs or symptoms of hypoglycemia, interventions implemented, physician or nurse practitioner notification, or follow-up monitoring after the blood sugar result of 54. A record review of the progress notes revealed there was no nursing note on 5/12/26 explaining why Resident #29's NovoLOG was not administered during the 0600 scheduled administration time when chart code SS was documented on the MAR without an actual blood sugar result recorded. A record review of the Orders - Administration Note dated 5/12/26 at 12:55 PM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29 refused the medication, no documentation of education provided to the resident regarding negative outcomes of refusal, and no documentation indicating physician notification. A record review of the Orders - Administration Note dated 5/12/26 at 4:04 PM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29 refused the medication, no documentation of education provided to the resident regarding negative outcomes of refusal, and no documentation indicating physician notification. A record review of the progress notes revealed there was no nursing note on 5/14/26 explaining why Resident #29's NovoLOG was not administered during the 0600 scheduled administration time when chart code SS was documented on the MAR without an actual blood sugar result recorded. A record review of the Orders - Administration Note dated 5/14/26 at 12:28 PM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29's signs or symptoms, interventions, physician notification, or follow-up monitoring. A record review of the Orders - Administration Note dated 5/15/26 at 5:11 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness BS is 65. There was no documentation indicating Resident #29's signs or symptoms of hypoglycemia, interventions implemented, physician or nurse practitioner notification, or follow-up monitoring after the blood sugar result of 65. A record review of the Orders - Administration Note dated 5/16/26 at 5:12 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29 refused the medication, no documentation of education provided to the resident regarding negative outcomes of refusal, and no documentation indicating physician notification. A record review of the Orders - Administration Note dated 5/17/26 at 11:21 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness refused bc (because) bs 81. There was no documentation indicating physician or nurse practitioner notification regarding the resident refusing scheduled insulin administration. A record review of the Orders - Administration Note dated 5/18/26 at 5:00 AM revealed, NovoLOG FlexPen.Monitoring Effectiveness. There was no documentation indicating Resident #29 refused the medication, no documentation of education provided to the resident regarding negative outcomes of refusal, and no documentation indicating physician notification. A record review of the Orders - Administration Note dated 5/19/26 at 6:05 AM revealed, Gvoke PFS Subcutaneous Solution Prefilled Syringe 1 MG/0.2ML Inject 1 syringe subcutaneously as needed for hypogylemia related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED (E11.40). A record review of the General Notes dated 5/19/26 at 6:05 AM revealed, Resident hypoglycemic BS66, Gvoke given. BS up to 105. There was no documentation indicating physician or nurse practitioner notification, Resident #29's signs or symptoms of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypoglycemia, or rationale for administration of glucagon rather than oral intervention. On 5/20/26 at 2:00 PM, during an interview and record review with the Director of Nursing (DON), she reviewed Resident #29's physician orders. The DON reviewed the MAR documentation and acknowledged there were entries that required further explanation, such as with chart code SS without actual blood sugar results documented, a blood sugar result of 54 without documentation of physician notification, holding and not administering insulin without physician notification, resident refusing without physician notification, and administration of glucagon on 5/19/26 without documentation indicating physician notification or the resident's signs and symptoms. She explained nurses remained responsible for administering medications according to standards of care. The DON stated nurses may have been afraid to administer insulin if the resident's blood sugar was low; however, the nurses should have contacted the physician for further orders. The DON stated nurses should monitor for signs and symptoms of hypo/hyperglycemia every shift and document. The DON stated if a fasting glucose level was low and the resident was awake, staff would typically provide food to attempt to increase the resident's blood sugar. On 5/20/26 at 4:30 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, she stated Resident #29's blood sugar had been running in the lower range recently. LPN #1 stated the resident's blood sugar had been in the 70s on previous mornings and when the blood sugar registered in the 60s on 5/19/26, the resident was trembling and not himself, so she administered the glucagon to raise the resident's blood sugar quickly. LPN #1 stated she was uncomfortable with the resident's blood sugar being that low and with the symptoms the resident displayed. LPN #1 stated the resident's blood sugar increased after glucagon administration and the resident returned to his normal baseline. LPN #1 stated there were no instructions on the MAR indicating a specific blood sugar level or symptoms required before glucagon administration. LPN #1 stated she did not notify the physician or nurse practitioner because the resident's blood sugar improved and there were no MAR instructions directing her to notify the physician or nurse practitioner. On 5/21/26 at 10:15 AM, during an interview with the Nurse Practitioner (NP), she stated she preferred to be notified when a resident's blood sugar was less than 70 or greater than 400. The NP stated she would like Gvoke to be administered for blood sugar results less than 70 and believed the facility would be adding those instructions to the administration order for Resident #29. The NP explained that the facility staff should document actual blood sugar results, including an explanation of why insulin was not administered as ordered, and notify her anytime a medication is held. She also requested to be notified when residents refuse medications such as insulin so she could provide education to the residents and/or their responsible representatives. A record review of the admission Record revealed the facility admitted Resident #29 on 1/18/25 with diagnoses including Diabetes Mellitus (DM). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #29 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 Resident #29 received seven (7) insulin injections during the seven (7) day look-back period. Resident #92 A record review of Section H of the Discharge – Return Anticipated MDS with an ARD of 2/21/26 revealed Resident #92 did not have an indwelling catheter when discharged to an acute care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Quitman	191 Highway 511 East Quitman, MS 39355

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital. A record review of the Discharge Summary from the acute care hospital, dated 2/25/26, revealed Resident #92 had instructions for .Foley (indwelling catheter) being kept in place for discharge. A record review of the facility's Progress Note, dated 2/26/26, revealed Resident #92 returned to the facility from the acute care hospital and included, Resident with Foley catheter in place. A record review of Resident #92's medical record revealed there was no documentation indicating indwelling catheter care or monitoring from the date the resident returned to the facility on 2/26/26 until 5/4/26, approximately ten (10) weeks after returning to the facility. A record review of the Order Summary Report revealed Resident #92 had Physician's Orders, dated 5/4/26 for a Foley catheter. A record review of the May 2026 Treatment Administration Record revealed indwelling catheter care for Resident #92 was initiated on 5/4/26. This was the first documentation identified related to catheter monitoring and placement since Resident #92 returned to the facility on 2/26/26. On 5/21/26 at 11:15 AM, during an interview with the Director of Nursing (DON), she stated the charge nurse was responsible for entering physician orders into the system following a resident's return from the hospital. The DON confirmed Resident #92's catheter was placed during the hospitalization from 2/21/26 through 2/26/26 and remained in place after the resident returned to the facility. The DON stated staff were monitoring and emptying the catheter; however, she was unable to explain why facility staff did not identify there was no documentation area for catheter monitoring or care and no physician orders related to the indwelling catheter until 5/4/26. The DON confirmed no physician orders related to the catheter, catheter monitoring, or catheter care were entered into the computer system until 5/4/26. On 5/21/26 at 2:30 PM, during an interview with the Administrator, she stated physician orders should have been entered into the system upon Resident #92's return from the hospital in February 2026. The Administrator stated the receiving nurse was responsible for entering orders and the unit manager was responsible for supervising the process to ensure orders were properly entered. The Administrator further stated if discharge orders were incomplete or were in question, nursing staff should have contacted the hospital to clarify physician instructions. A record review of the admission Record revealed the facility admitted Resident #92 on 5/17/21 with diagnoses including Obstructive Uropathy and Reflux Uropathy. The record further revealed an onset date of 5/4/26 for the diagnoses. A record review of the Quarterly MDS with an ARD of 5/18/26 revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, record review, and facility policy review, the facility failed to store oxygen tubing and a nasal cannula in a manner to prevent possible contamination and respiratory complications for one (1) of (1) residents reviewed for respiratory care. Resident #29. Findings include:A review of the facility's policy, Oxygen Guideline, dated 8/1/2024, revealed, .Medical oxygen.is provided in accordance with a health care provider's order and in accordance with acceptable standards of practice.A record review of the admission Record revealed the facility admitted Resident #29 on 1/19/25 with diagnoses including Diabetes Mellitus (DM).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.A record review of the Order Summary Report revealed Resident #29 had a physician order dated 5/8/26 for Oxygen at 2L (liters) per nasal cannula for decreased oxygen saturation PRN (as needed) for decreased saturation.On 5/18/26 at 10:45 AM, during an observation, Resident #29 was sleeping in bed. Oxygen signage was observed on the resident's door. Resident #29 was not wearing the nasal cannula at the time of the observation. An oxygen concentrator was in the resident's room with the nasal cannula tubing lying on top of the concentrator with the nasal cannula exposed and not stored in a protective bag.On 5/20/26 at 2:45 PM, during an observation and interview, Resident #29 was in bed and stated he had not worn his oxygen in a couple of weeks. The oxygen concentrator remained in the room with the tubing lying on top of the concentrator and the nasal cannula exposed and not stored in a protective bag.On 5/20/26 at 3:00 PM, during an observation and interview with the Director of Nursing (DON), she confirmed the oxygen tubing and nasal cannula were stored with the nasal cannula exposed. The DON explained the tubing should have been stored in a bag. The DON stated she expected staff to ensure nasal cannula tubing was stored appropriately and reported Resident #29's oxygen was ordered PRN and she would have the oxygen concentrator removed from the room.