STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255100	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Tylertown	200 Medical Circle Tylertown, MS 39667

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews, record review and facility policy review, the facility failed to ensure that residents who receive meals in their rooms were informed of their daily menu options and provided the opportunity to make meal choices for two (2) of (14) residents reviewed for choices. Resident #22 and Resident #37.Findings include: A review of the facility policy, Menu revised 10/22, revealed, Menus will be planned in advance to meet the nutritional needs of the residents .will adjust the individual meal plan to meet the individual requests, including cultural, religious or ethnic preferences .Resident #22During an initial interview on 1/11/26 at 11:34 AM, Resident #22 stated that since arriving at the facility a few months ago, she has preferred to eat in her room. She reported that due to health reasons, she is unable to get up freely and requires staff assistance to get out of bed. She explained that during her stay, the staff had not informed her of menu choices or that she could choose something different from what was brought to her. She stated that, because there is no menu in her room, she believed she had to eat whatever was delivered, and if she did not like it, she would wait until dinner and hope it was something she preferred. She added that having more than one option to choose from would be very beneficial.On 1/12/26 at 1:02 PM, during an interview, Resident #22 revealed that no one has come by to let her know her food choices for the day. She said she did not eat her lunch because it was not good and decided to wait until dinner to see what would be served.On 1/13/26 at 10:02 AM, Resident #22 indicated that no one has come by to let her know about her food choices.On 1/14/26 at 9:02 AM, during a final interview, Resident #22 indicated that no one has come to pick up her food choices.A record review of the admission record revealed the facility admitted the resident on 9/12/25 with diagnoses that included Acute Diastolic Congestive Heart Failure.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/25 revealed a Brief Interview Mental Score (BIMS) score of (15) indicating the resident was cognitively intact. Resident #37During an interview on 1/14/25 at 8:30 AM, conducted as a follow-up to the Resident Council Meeting, Resident #37, the Council President, reported that she is dependent on staff to help her get in and out of her room by wheelchair, so she cannot walk to the dining hall to see what is being served. She explained that she is not aware of an alternate menu. She said it was her understanding that she had to eat whatever was brought to her room, and if she did not want it, she simply did not eat. She further noted that no one currently informs her or her roommate about what is being served for lunch or any meal, and there is no menu in their room. She added that she would like to know what she is having ahead of time so she can choose something she likes.At 8:36 AM on 1/14/26, during an interview with the Dietary Manager, she confirmed that there are no menus in the residents' rooms. She reported that she is not sure whether a system exists to honor residents' meal preferences on a day-to-day basis. She acknowledged that residents should have a choice in what they want to eat.At 8:54 AM on 1/14/26, during an interview with Certified Nursing Assistant #1 (CNA), who confirmed she works with Resident #22, indicated that there is (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no established process in place to ensure residents are aware of their meal choices for the day.At 11:25 AM on 1/14/26, during an interview with the Administrator, she shared that she has identified the need for residents to know their meal options. She explained that this issue has been ongoing for quite some time and that the facility has not yet identified a solution. A record review of the admission Record revealed the facility admitted the resident on 2/9/24 with diagnoses that included Hemiplegia and Hemiparesis following Cerebrovascular Disease Affecting the Left Dominant Side.A record review of the MDS with an ARD of 11/13/25 revealed a BIMS score of 15 indicating the resident was cognitively intact.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews, record reviews and facility policy review the facility failed to obtain a physician order to flush Percutaneous Endoscopic Gastrostomy (peg) tubes with water before and after administering medication via peg tube for one (1) of six (6) residents with peg tubes. Resident #32.Findings include: Record review of the facility policy Eternal Tube Medication Administration with a review date of 04/22 revealed .Crushed medications, contents of opened capsules as well as liquid medications are diluted with at least 5 milliliters (ml) of water when fluid is not restricted .Following drug administration, flush the tube with a final flush of at least 30 ml of water. On 01/13/2026 at 2:15 PM, LPN #2 was observed giving peg medications to Resident #32 via peg tube. The following medications were administered Buspirone 10 milligrams (mg) Hydroxyzine 25 mg, and Trazadone 50 mg via peg tube. LPN#2 flushed the peg tube with 30 cc water before and after medications administration. A record review of Resident #32 Order Summary Report with active orders as of 1/13/26 revealed physician orders for Buspirone HCl 10 milligrams (mg), Hydroxyzine 25mg, and Trazadone 50mg via peg tube. The physician's orders did not include an order to flush or the amount to flush before and after administering medications. A record review of Resident #32 admission Record revealed an admission date of 10/22/25 with diagnoses that included of Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Dysphagia following Cerebral Infarction. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. On 01/14/2026 at 8:08 AM, in an interview the Director of Nursing (DON) stated we go by our policy for flushing peg tubes with water. She confirmed they do not have a physician order for flushing peg tubes when administering medications.

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Diversicare of Tylertown	200 Medical Circle Tylertown, MS 39667

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to properly secure and store medications and wound care supplies for two (2) of four (4) days of survey.Findings include:Record review of the facility policy Medication Storage updated 04/22 revealed .Medications are accessible ONLY to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . On 1/13/26 at 3:07 PM, the wound care cart was observed unattended and unlocked on the resident care unit. The cart remained unsecured until 3:10 PM, when Registered Nurse (RN) #2 was observed walking past and locking it.On 1/13/26 at 3:10 PM, in an interview, RN #2 stated that the wound care nurse was the last to use the cart before going into a resident's room and must not have locked it. She confirmed the cart should remain locked when not in use to prevent resident access.On 1/14/26 at 9:04 AM, the wound care cart was again observed unlocked and unattended in the hallway. It remained unsecured until 9:07 AM, when RN #1 came down the hall and locked it.In an interview on 1/14/26 at 9:13 AM, RN #3, the wound care nurse, stated that the wound care cart should remain locked at all times when not in use because it contains chemicals that could pose a risk to residents if accessed, ingested, or come into contact with eyes.On 1/14/26 at 9:14 AM, a direct observation of the wound care cart revealed the following items were unsecured and readily accessible: a staple remover, wound cleanser, nystatin antifungal cream, aloe moisturizer, Bio freeze topical anesthetic, triple antibiotic ointment, and iodoform gauze.On 1/14/26 at 9:40 AM, during an interview, RN #1 confirmed that the wound care nurse was the last to access the unlocked cart and reiterated that the cart must be locked when unattended to prevent potential harm to residents.On 1/14/26 at 9:55 AM, during an interview, the Director of Nursing (DON) confirmed that the wound care cart should remain locked at all times when not actively in use to ensure residents do not come into contact with any potentially harmful substances stored in the cart.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection during wound care and medication administration via Percutaneous Endoscopic Gastrostomy (peg) tube for three (3) of (10) care and medication observations. Resident #4, Resident #32 and Resident #49.Findings included: Record review of the facility's policy Infection Control dated 11/1/17 revealed, Policy Statement: This center's infection control policies and practices are intended to facilitate maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infection . Resident #4 On 01/13/26 at 10:26 AM, during an observation, Resident #4 received Liquid Protein Supplement 30 milliliters (ml) administered by Licensed Practical Nurse (LPN) #1. LPN#1 retrieved the syringe from the pole and attempted to flush peg tube with 30 cubic centimeter (cc) water. She was unable to flush tube. She got a cup off bedside table and poured 30cc water in it. She went to sink in resident room and turned on faucet to get warm water. She checked placement again and attempted to flush peg tube. She was still unable to flush it with 30 cc's of water. She went back to the sink and turned in faucet and to get warm water. She returned and checked placement again. The pump started to beep, and she placed it on hold again at this time she was able to flush line. She administered the liquid protein and flushed with 30 cc's of water after administering protein liquid supplement. LPN #1 did not perform hand hygiene or change gloves throughout the process from the time she entered the room until the actual medication was administered. On 01/13/26 at 2:58 PM, an interview with LPN #1 confirmed that she did not wash hands or change gloves throughout the process. She stated that it left the resident vulnerable to bacteria and germs. Record review of the Order Summary Report with active orders as of 1/13/26 revealed physician orders for Liquid protein supplement one time a day for wound healing. Give 30 milliliters (ml) via peg tube. Record review of Resident #4 admission Record revealed an admit date of 5/9/24 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Dysphagia Oropharyngeal Phase. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident was severely impaired cognitively. Resident #32 Observation on 01/13/2026 at 2:15 PM, LPN #2 was observed giving peg medications to Resident #32 via peg tube. During the process, the nurse put on gloves and touched the bedside pump turning it off with gloves on, then wearing those same gloves to access the peg tube and give the meds. Once she completed the medication administration, LPN#2 used those gloves to turn the pump off, (touching buttons) on the bedside pump with the contaminated gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 1/13/26 at 2:40 PM, with LPN #2, she stated that she should have either used bare hands to turn the pump off or changed gloves after touching the pump prior to accessing the peg tube medications and removed or changed gloves prior to touching the pump at the end of the procedure to turn it off. On 01/14/26 at 9:50 AM, an interview with the Director of Nursing (DON) confirmed that residents have an increase in the chance of infection when hand hygiene is not done. She confirmed that LPN #1 and LPN #2 have should perform hand hygiene and changed gloves during the process. She stated her expectations are for staff to provide care in a way to prevent infection. A record review of Resident #32 Order Summary Report with active orders as of 1/13/26 revealed physician orders for Buspirone HCl 10 milligrams (mg), Hydroxyzine 25mg, and Trazadone 50mg via peg tube. A record review of Resident #32 admission Record revealed an admission date of 10/22/25 with diagnoses that included of Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Dysphagia following Cerebral Infarction. A record review of the MDS with an ARD of 10/29/25 revealed a BIMS score of 99 which indicated the resident was unable to complete the interview. Resident #49 During wound care observation on Resident #49 at 9:17 AM, on 1/13/26, the wound care nurse Registered Nurse (RN) #3 provided wound care starting with an open unstageable wound and was observed cleaning four other separate necrotic wounds to the foot (each one at a separate site), during which she wore the same gloves, reaching the contaminated glove hand into a container filled with saline-soaked gauze and using those gauze to clean a separate wound each time without ever changing her gloves between she then doubled back over each wound making a separate pass to clean the each wound again after already cleansing each site while wearing the same gloves. In an interview at 9:40 AM on 1/13/26, with RN #3, stated that she thought the wounds were all considered one wound since they were on the same foot, so it was okay to use the same gloves. In an interview at 11:38 AM on 1/13/26, the DON stated that not changing gloves when you are supposed to can cause cross-contamination to other wounds during the wound care process and lead to infection. In an interview with RN #1, the Infection Preventionist nurse on 1/14/26 at 9:38 AM, stated that not following infection prevention guidelines and changing gloves properly could lead to an increased risk of infection for residents receiving care. A record review of the admission Record revealed the resident was admitted on [DATE] with diagnoses that included hypertensive heart and chronic kidney disease. A record review of the MDS with an ARD of 12/18/25 revealed a BIMS score of 13 which indicated no mental impairment.