STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and four Complaint Investigations (CI) MS #27703, CI MS #27184, CI MS #27940, and CI MS #27952 at the facility from 2/10/25 through 2/13/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F550, F576, F584, F604, F623, F641, F655, F656, F677, F684, F698, F755, F758, F761, F806, F867, and F880. The SA identified non-compliance and cited F584 for environmental issues for CI MS #27703. The SA identified non-compliance and cited F604 regarding physical restraints for CI MS #27952. The SA investigated CI MS #27184 and CI MS #27940 with no deficiencies cited. The census at the time of the survey was 114 and the facility was licensed for 152 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/07/2025

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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure residents had the right to participate in smoking during rainy or inclement weather for two (2) of four (4) survey days. Resident #60, 65, A, and B. Findings include: Review of the facility policy titled, "Resident Rights & Quality of Life Policy" with an effective date of 3/13/20, revealed, "It is the policy of	F 550	1. Residents #60, #65, A and B and other residents who smoke were offered and assisted to the smoking area on 2/13/25 by staff member. Education completed on 2/27/25 with staff on residents rights to include the smoking policy and smoking times to assure compliance by the Director of Clinical Education. 2. All residents with the desire to smoke are at risk of the deficient practice. 3. Notification of the smoking policy was provided to the residents who smoke on	

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F 550	Continued From page 2 "proper name" that all patients and residents have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center...A patient or resident has the right: To be fully informed of his or her rights and all rules and regulations governing patient and resident conduct and responsibilities during the stay in the center." Review of "Proper name Smoke Schedule" undated, revealed ** Staff members are not allowed to take residents out to smoke during inclement weather, such as: Rain, Sleet, Snow, Hail, Storms, Heat index of 100+ and freezing temp of 32 degrees and below. ** In an interview on 2/12/25 at 8:35 AM, Resident #60 revealed that she wanted to go out and smoke, but they won't take anyone because it is raining outside. She stated she would really like to have a cigarette, plus we didn't get to go out yesterday and smoke all day because it was raining. During an interview on 2/12/25 at 8:45, Certified Nurse Aide (CNA) #8, with Resident #60 present, confirmed that the residents aren't allowed to go out today and smoke because it is raining. She revealed they aren't allowed to go out if it's raining, snowing, bad weather, or cold. During an observation and interview on 2/12/25 at 11:05 AM, Resident #60 was sitting in her doorway in her wheelchair and stated that she really wanted to go out and smoke, but we still can't because it's still raining. In an interview on 2/12/25 at 11:15 AM, Central	F 550	3/4/25 by the Administrator. A resident council meeting was conducted by the Administrator on 3/4/25 to discuss the current smoking times and variances that may occur due to weather concerns. Education was provided by the Director of Clinical Education on 2/27/25 to staff to ensure residents that desire to smoke will be assisted by staff to the smoking area during scheduled smoking times when weather concerns are present based off the residents choice to attend. 4. On 2/28/25, the Administrator began an audit of three residents weekly x four weeks then monthly x two months to ensure compliance with the smoking schedule. The results of the audit will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 550	Continued From page 3	F 550		

Supply revealed that the person that is assigned to take the smokers out at 11 AM is the Minimum Data Set (MDS) #1, but she probably won't do it because it's raining. She then confirmed that the residents don't go out to smoke if it's raining, so they did not get to go yesterday either.

An observation and interview on 2/12/25 at 11:25 AM revealed several residents sitting by the smoking door waiting for the 11 AM smoke break. Resident A and Resident #60 both revealed they hoped they would let them, especially since they missed yesterday because it rained all day.

An observation and interview on 2/12/25 at 11:30 AM, MDS #1 arrived at the door to the smoking area with the residents still waiting and stated that they do not usually take them out to smoke when it's raining or inclement weather.

An interview on 2/12/25 at 11:35 AM with Resident A, B and #65. Resident A stated, "I don't understand why we can't come out to smoke, because we have a pavilion to sit under and it helps my nerves. Resident B revealed he wishes they would let them go out and smoke regardless of the weather when it is their smoke break time. Resident #65 stated, "I didn't get a cigarette all day yesterday because it was raining."

During an interview on 2/12/25 at 2:35 PM with the Admission Liaison she revealed it is her responsibility to complete admission paperwork with the residents and their families. She stated that the admission paperwork does not address smoking. She revealed that if they ask, she does tell them that they allow smoking, but they do not sign anything.

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F 550	Continued From page 4	F 550		

An interview on 2/12/25 at 3:37 PM, the Administrator (ADM) confirmed that the residents do not have to sign anything regarding smoking rules. She revealed that they discuss smoking rules during the 72-hour report after admitting the residents and confirmed that she understands that residents have their rights.

Record review of Resident #60's "Admission Record" revealed the facility admitted the resident on 6/28/2023 with diagnoses that included Major Depressive Disorder, and Nicotine Dependence, Cigarettes.

Record review of Resident #60's MDS with an Assessment Reference Date (ARD) of 11/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

A record review of Resident #65's "Admission Record" revealed the facility admitted the resident on 10/14/2023 with diagnoses that included Heart Failure, Major Depressive Disorder, and Nicotine Dependence on Cigarettes.

A record review of Resident #65's MDS with an ARD of 12/9/24 revealed, under section C, a BIMS score of 15, which indicated that Resident #65 is cognitively intact.

Record review of Resident A's "Admission Record" revealed the facility admitted the resident on 1/9/2025 with diagnoses that included Displaced Trimalleolar Fracture of the Left Lower Leg, Encounter for Closed Fracture with Routine Healing, Weakness, and Bipolar Disorder.

A record review of Resident A's MDS with an ARD

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F 550	Continued From page 5 of 1/16/25 revealed, under section C, a BIMS score of 15, which indicated the resident is cognitively intact. A record review of Resident B's "Admission Record" revealed the facility admitted the resident on 11/27/2023 with diagnoses that included Anxiety Disorder and Major Depressive Disorder. A record review of Resident B's MDS with an ARD of 11/14/24 revealed, under section C, a BIMS score of 13, which indicated that the resident is cognitively intact.	F 550		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576		3/14/25

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F 576	Continued From page 6 service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to deliver resident mail on Saturdays for four (4) of ten (10) residents present during the Resident Council meeting. Resident #8, #14, #25, and #38. Findings include: Review of the facility policy, titled "Residents' Rights Summary" unrevised, revealed, "9. Mail: The resident has the right to privacy in written communications, including the right to send and receive mail promptly and unopened and have access to stationery, postage, and writing implements at the resident's expense." During a Resident Council meeting on 2/11/25 at 11:00 AM, Resident's #8, #14, #25 and #38 voiced that they have not been getting mail delivered to them on Saturday. The residents revealed they could not recall the last time they	F 576	1. The Administrator met with residents #8, 14, 25, 38 on 2/28/25 to assure the timely delivery of mail including on weekends will be enforced. Education was provided 2/27/25 to Social Services to assure understanding of mail delivery to residents including weekends by the Director of Clinical Education. 2. All residents who receive mail have the potential to be affected by this deficient practice. 3. A resident council meeting was conducted on 3/4/25 to discuss mail delivery on weekends by the Administrator. Education was conducted by the Director of Clinical Education on 2/27/25 with staff on residents rights to ensure mail is delivered six days per week (excluding holidays) to residents. Going forward, Manager on Duty (MOD) is to ensure this process is followed and mail is	

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F 576	Continued From page 7 did. Resident #25 stated that the facility did not have anyone available to distribute the mail on Saturdays, so it just stayed in the mailbox until the social worker was back during the week. She explained that if anyone was waiting for a card or letter, they would have to wait for it. An interview with Social Services (SS) #1 on 2/11/25 at 12:05 PM, confirmed the residents were not getting mail on Saturdays. She explained the mail was always left for her to pass out. SS #1 revealed it was important for the residents to receive their mail and stated, "I would want mine." An interview with the Administrator (ADM) on 2/12/25 at 2:18 PM revealed the facility had a manager on duty Saturdays that was responsible for passing out the mail. She revealed she was not aware it was not being done. The ADM confirmed the mail should be passed out to the residents on days the mail ran. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 7/25/12. Record review of Resident #8's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/25 revealed under, section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #14 on 11/27/12. Record review of Resident #14's MDS with an	F 576	delivered on weekends. 4. On 2/21/25 the Administrator began an audit of a minimum of five residents weekly x four weeks then monthly x two months to ensure compliance of mail delivery including the weekends. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QApI meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 576	Continued From page 8 ARD of 11/11/24 revealed under, section C, a BIMS score of 15, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #25 on 9/15/20. Record review of the MDS with an ARD of 12/17/24 revealed under section C, a BIMS summary score of 15, which indicated Resident #25 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #38 on 12/29/17. Record review of the Quarterly MDS with an ARD of 12/12/24 revealed under, section C, a BIMS summary score of 15, which indicated Resident #38 was cognitively intact.	F 576		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		3/14/25

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F 584	Continued From page 9 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a safe, clean environment as evidenced by an unsanitary toilet in room C-7, resident wheelchair (Resident #60), overbed tables, and wall in disrepair affecting three (3) residents in the seventy-three resident occupied rooms observed. Resident #48, Resident #60 and Resident #99 Findings Include:	F 584	1. The overbed table for Resident #48 and #99 were repaired or replaced by Maintenance Director on 2/12/25. The arm rest of wheelchair for Resident #60 was replaced by the Maintenance Director on 2/28/25. The Director of Nursing ensure the wheelchair for Resident #60 was cleaned by the nursing staff on 2/13/25. The raised toilet seat in bathroom of C7 was replaced by the Maintenance Director on 2/12/25. The Maintenance Director painted the section	

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F 584	Continued From page 10 Review of the facility policy titled, "Resident Rights and Quality of Life Policy", dated 3/13/20, revealed, "A patient or resident has the right: ... to receive services in a center environment that is safe, clean, and comfortable ..." Review of the facility policy titled, "Resident/Patient Room Cleaning," last reviewed 2/1/2025, revealed Policy: Room Cleaning: "Rooms are to be regularly cleaned and disinfected with a particular focus on disinfecting high-touch surfaces such as light switches, bed rails, doorknobs, call lights, etc. ... Nursing staff provides the initial cleanup of blood and bodily fluids... Environmental services staff follow by disinfecting surfaces contaminated with a small, residual amount of feces, blood, or other bodily fluids..." Resident #48 An observation on 2/10/25 at 11:45 AM, revealed two (2) overbed tables in Resident #48's room. One overbed table was situated to the left of the bed, and the other overbed table was situated to the right of the bed. Both overbed tables had a thick red and black rust like appearance to the metal base of the overbed tables. The edges of both overbed tables were tattered and torn with edging missing. During an observation and interview on 2/11/25 at 3:30 PM, the Director of Nursing (DON) confirmed both overbed tables in Resident #48's room had thick rust on the metal frames, and the tabletops had torn and jagged edging and needed to be replaced. She stated, "These certainly need to be replaced."	F 584	of wall in the room of Resident #99 on 2/28/25. 2. All residents have the potential to be affected by this deficient practice. 3. On 2/27/25, all rooms were inspected by the Maintenance Director and/or the Assistant Maintenance Director to determine which, if any rooms and equipment, were in need of repairs or painting. All wheelchairs and overbed tables were inspected by the Administrator and Director of Nursing. Wheelchairs identified in need of cleaning were cleaned and washed on 3/5/25. The Administrator submitted an order for replacement of any overbed table in need of replacement on 2/24/25. Beginning 2/24/25 the Maintenance Director will check work orders daily. The Maintenance Director will report work orders and completion to the Administrator for verification and completeness weekly beginning 2/24/25. Beginning 2/28/25, the Director of Nurses devised a wheelchair washing schedule to assure that all wheelchairs will be cleaned timely. The Maintenance Director was in-serviced on room inspection and reviewing work orders and timely completion by the Director of Clinical Education on 2/27/25. Facility staff were in-serviced 2/27/25 on reporting damages to Maintenance for a safe, clean, comfortable and homelike environment. Nursing staff were educated on reporting any repair needs of wheelchairs, providing routine cleaning of wheelchairs according to assignments and providing cleaning of soiled resident equipment.	

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 584	Continued From page 11 A record review of Resident #48's "Admission Record" revealed the facility admitted the resident on 4/19/2019 with diagnoses that included Unspecified Dementia, Peripheral Vascular Disease, Contracture of the Right Hand, and Contracture of the Left Hand. Resident #60 An observation and interview on 2/10/25 at 10:45 AM, revealed Resident #60 sitting in a wheelchair with the left armrest vinyl tattered and torn. Resident #60 revealed that she has been in this wheelchair for three weeks, and the armrest was torn when they gave it to her. A dark-gray thick substance was noted on the frame and the spokes of the wheels. During an interview on 2/11/25 at 3:10 PM, Certified Nursing Assistant (CNA) #5 revealed the night shift CNAs are responsible for cleaning the wheelchairs. She revealed that we let the Maintenance Director know about any equipment or furniture in a resident's room that needs to be replaced or repaired and admitted that she had not told anyone about the wheelchair armrest. During an interview and observation on 2/11/25 at 3:20 PM, the DON confirmed that Resident #60's wheelchair armrest was torn and tattered and could cause a skin tear. She revealed that the night shift staff is responsible for ensuring that the wheelchairs are clean and confirmed that the wheelchair had a gray substance on the frame and needed to be cleaned. Record review of Resident #60's "Admission Record" revealed the facility admitted the resident on 6/28/2023.	F 584	4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator and the Maintenance Director will make rounds one x week x four weeks beginning 2/27/25, then monthly to ensure a safe, clean, comfortable, homelike environment. The Administrator and Director of Nursing will make rounds one x week x four weeks beginning 3/4/25, then monthly to ensure wheelchairs are clean and no repairs needed. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 584	Continued From page 12	F 584		

Record review of Resident #60's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/27/24, revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

C-7 Bathroom

An observation 2/10/25 at 10:45 AM, of the bathroom in room C-7 revealed a raised toilet seat that had a large dark brown dried substance on the back of the toilet seat rim, and a smeared dark brown substance was also on the metal bar at the top of the back of the raised toilet seat.

An observation of the bathroom of room C-7 with CNA #3 on 2/11/25 at 1:25 PM, she confirmed there was a large dried dark brown substance on the back of the toilet seat rim and a smeared dark brown substance on the metal bar at the top of the back of the raised toilet seat that appeared to be stool. She stated concerns about the toilet not being clean is that it is not sanitary and could lead to the spread of infection. She then stated the nursing staff are responsible for cleaning the toilets or any equipment or surface that is contaminated with bodily secretions.

An interview with the DON on 2/11/25 at 2:05 PM, she confirmed that nursing staff are responsible for cleaning equipment that is soiled with bodily fluids. She stated concerns from not sanitizing the toilet is an infection control concern and sanitation issue and could lead to infections.

In an interview with Housekeeper #2 on 2/12/25 at 2:00 PM, she revealed housekeeping should notify their supervisor and nursing staff if they find

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 584	Continued From page 13	F 584		

a room that has surfaces or equipment soiled with bodily fluids. She then stated that the housekeeping staff clean the contaminated surfaces after nursing has cleaned the surfaces.

Resident #99

During the initial tour on 2/10/25 at 11:40 AM, an observation revealed a large section of paint, measuring approximately two feet wide by one and a half feet high, missing from the wall behind Resident #99's headboard. The resident's overbed table was observed to have rust on the entire metal frame. During an interview, Resident #99 stated he would like to have the paint repaired and the table replaced.

During an observation of Resident #99's room with the DON and interview on 2/11/25 at 3:25 PM, the DON confirmed the wall needed repair. She stated the maintenance department is responsible for the repair of damaged walls and it was the staff's responsibility to report these concerns so they could be addressed. She stated it was also the staff's responsibility to ensure the residents' equipment was in good repair, and this overbed table did not meet that standard. She confirmed each resident should have a room that is clean, comfortable and homelike and the facility failed to provide this for Resident #99.

An interview on 2/12/25 at 8:50 AM, with the Administrator confirmed that the maintenance staff was responsible for painting and repairing damage. She stated the paint concern had been noted on the room rounds previously but had not been repaired. She confirmed each resident has

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F 584	Continued From page 14 the right to a safe, comfortable, home-like environment and the facility failed to provide this for Resident #99. Record review of Resident #99's "Admission Record" revealed the facility admitted the resident on 1/23/25 with medical diagnoses that included Traumatic Subdural Hemorrhage, Dysphagia, and Epilepsy. Record review of Resident #99's Admission MDS with an ARD of 1/30/25 revealed a Brief Interview for BIMS score of 9 which indicated the resident had a moderate cognitive impairment.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		3/14/25

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F 604	Continued From page 15 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from physical restraints as evidenced by restricting a resident's voluntary movement by body contact for one (1) of 23 sampled residents. Resident #88 Findings Include: Review of the facility policy titled "Residents' Rights Summary" unrevised, revealed under, "Examples of Violations: ... 12. Restraining a resident without a physician's order for the convenience of staff, or as a disciplinary measure." An observation on the Memory Care Unit on 2/11/25 at 3:49 PM revealed Resident #88 sitting in a wheelchair in the activity room and Certified Nurse Aide (CNA) #4 was standing in front of the resident with her right knee in between the residents' legs. The resident was anxious and asked the aide to take her to the bathroom. The resident tried to stand up from the wheelchair several times but was stopped. CNA #4 replied, "No, you've got to stay right here" while touching the resident's leg and instructing her to sit down because she had just went to the bathroom. The	F 604	1. On 2/11/2025, Certified Nurses Assistant CNA#4 was removed from resident care and suspended pending investigation as it is not the policy of Diversicare to use restraints. 1:1 education regarding resident rights and restraints was provided to this Certified Nurses Assistant (CNA) by the Director of Nursing (DNS) prior to the CNA leaving the center on 2/11/2025. Resident #88 was assessed by the DNS on 2/11/25 for unmet needs and emotional status with no negative outcomes identified. 2. All residents have the potential to be affected by this practice. 3. A resident council meeting was conducted on 2/18/2025 to inquire as to whether residents feel safe at the center and all residents in attendance voiced no safety concerns. On 2/27/2025 education was provided to staff members on resident rights and restraints by the Director of Clinical Education (DCE). On 2/12/2025 education was provided to staff members by the DCE on Abuse and Neglect. 4. On 2/24/2025, the Administrator and DNS began an audit of a minimum of five	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 604	Continued From page 16 resident continued rocking forward in her wheelchair. An observation and interview with the Memory Care Unit Coordinator on 2/11/25 at 4:01 PM confirmed CNA #4 was standing over Resident #88 and restricting her from voluntarily standing up. She revealed CNA #4 was doing that to keep the resident from getting out of the chair and falling. She stated that the resident had just been toileted and was frequently asking to go to the bathroom. The Memory Care Coordinator revealed the resident was on a toileting program and should be toileted every two (2) hours and when needed. An interview with the Administrator (ADM) on 2/11/25 at 4:08 PM confirmed the aide's actions were not how the facility should be handling the residents. She stated that she had been made aware of the incident witnessed between CNA #4 and Resident #88. She revealed the resident's request to go to the bathroom could be a behavior or a urinary tract infection. An interview with the Director of Nursing (DON) on 2/11/25 at 4:13 PM confirmed that CNA #4's action was restraining Resident #88 from standing up from the wheelchair. An interview with CNA #4 on 2/11/25 at 4:18 PM revealed she was trying to prevent Resident #88 from getting up and falling. She explained the resident was a fall risk and always asking to go to the bathroom because she wanted to go and stay in her room. An interview with the Nurse Practitioner (NP) on 2/12/25 at 10:08 AM revealed Resident #88 had	F 604	Memory Care residents to ensure no use of restraints. This audit will be weekly x four weeks, then monthly for an additional two months. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 604	Continued From page 17 declined over the past three (3) months with an increase in behavior and restlessness. She explained that the resident had been up walking but recently required a wheelchair because she was unsteady. She revealed frequent bathroom requests had started around the same time and the resident was currently on an antibiotic for a urinary tract infection (UTI) which could be increasing her behavior. An interview with Registered Nurse (RN) #3 on 2/13/25 at 8:38 AM revealed the Memory Care Unit had a fall risk area where the residents that were at risk stayed, so they were overseen closely by the staff. She revealed the aides were to watch over the residents and oversee but never prevent a resident from getting up. Record review of CNA #4 "Education Transcript" revealed she was trained on preventing falls (8/15/24), dementia care (8/16/24), and dementia with challenging behaviors (1/21/25). Record review of the "Admission Record" revealed the facility admitted Resident #88 on 3/19/24 with a diagnosis that included Alzheimer's Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/24 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #88 was severely cognitively impaired.	F 604		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		3/14/25

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F 623	Continued From page 18	F 623		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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F 623	Continued From page 19 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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F 623	Continued From page 20 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to mail a written notification of hospital transfer notice to a resident's Resident Representative (RR) for two (2) of two (2) residents reviewed for hospitalization. Resident #63 and #102 Findings Include: Review of the facility policy titled "Transfer & Discharge" unrevised, revealed under, "Notice Requirements: 4. Before 'Proper name of the facility' transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand ..." Record review of Resident #63's "Progress Notes" dated 1/3/25 revealed the resident was transferred to the hospital following a fall. Record review of Resident 102's "Progress	F 623	1. Written notifications for the facility initiated transfer to the hospital were mailed to resident #63 and #102 representative parties (RP) on 3/4/25 by the Social Worker (SW). Education was provided by the Administrator on 3/4/25 to the Social Worker to assure notification of transfers and/or discharges from the center are provided to residents or RPs. 2. All residents have the potential to be affected by the deficient practice. 3. An audit of residents transferred to the hospital in the past three months was completed on 3/5/25 by the Social Worker for evidence of a transfer/discharge notice provided. Any missing notifications were corrected immediately. Education was completed by the Director of Nursing on 3/5/25 with licensed nurses on transfer/discharge notification requirements and RPs to assure compliance going forward. 4. On 2/28/25, the Administrator began a	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 623	Continued From page 21 Notes" dated 1/27/25 revealed the resident was transferred to the hospital for altered mental status. An interview with Social Services (SS) #1 on 2/12/25 at 9:18 AM confirmed she did not mail Resident #63 and Resident #102's written notification of hospital transfer to the RR. She explained that she was never instructed by the previous social worker to do that and did not realize that was her responsibility. An interview with the Administrator on 2/12/25 at 2:18 PM revealed Social Services was responsible for mailing out hospital transfer notices. She confirmed written notification of hospital transfer should have been mailed to the RRs for Resident #63 and Resident #102. Record review revealed the facility admitted Resident #63 on 7/25/23 with a medical diagnosis that included Alzheimer's Disease. Record review revealed the facility admitted Resident #102 on 1/23/25 with a medical diagnosis that included Cerebral Infarction due to Unspecified Occlusion or Stenosis of the Left Cerebellar Artery.	F 623	weekly audit of residents transferred to the hospital to verify written notification was provided to the resident or RP by the Social Worker. This audit will be four weeks then monthly x two. The results of the audits will addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to	F 641	1. Modification on 2/11/2025 of Minimum Data Set (MDS) identified on Resident	3/14/25

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 641	Continued From page 22 accurately complete an assessment for the Minimum Data Set (MDS) medication section as evidenced by an antiplatelet medication being entered as an anticoagulant medication for one (1) of 23 sampled residents. Resident #25 Findings include: Record review of the Resident Assessment Instrument (RAI) "Care Area Assessment (CAA) Process and Care Planning" dated 10/24, revealed, "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas ... The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care." Record review of Resident #25's quarterly MDS Section N - Medications with an Assessment Reference Date (ARD) of 12/17/24, revealed anticoagulant medication was coded as "Yes", the resident was receiving an. This review also revealed antiplatelet medication was coded as "No". Record review of Resident #25's "Order Summary Report" revealed an order dated 10/2/18 for Brilinta Tablet 90 mg (milligrams) two times a day related to Cerebral Ischemia. An interview on 2/11/25 at 2:55 PM, with MDS Coordinator #1 revealed she was responsible for completing the MDS assessments and confirmed that Resident #25 was on an antiplatelet medication, and it was entered incorrectly as an	F 641	#25 to correctly code the antiplatelet completed by Registered Nurse Assessment Coordinator (RNAC). No negative outcome for the resident noted by the Director of Nursing (DNS). 2. All residents receiving an antiplatelet medication are at risk for the deficient practice. 3. 100% audit completed on 2/12/25 of current residents receiving an antiplatelet medication to determine any coding discrepancies. No additional discrepancies were found and no other modifications were required. RNAC education provided on 3/3/2025 for coding on residents receiving an antiplatelet medication on MDS per Resident Assessment Instrument (RAI) Guidelines per Clinical Reimbursement Specialist. 4. DNS, RNAC, and Director of Care Coordination will monitor five assessments completed each week for four weeks, then monthly for two months to identify any inaccuracy of coding antiplatelet medications beginning on 2/25/2025. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 641	Continued From page 23 anticoagulant medication. She stated the MDS was an indicator of the health and abilities of each resident and must be accurate for each residents' assessment to reflect the resident's condition. During an interview on 2/12/25 at 3:05 PM, the Director of Nursing (DON) confirmed the facility failed to accurately complete an MDS assessment for an antiplatelet medication (Brilinta) being entered as an anticoagulant medication for Resident #25. She admitted that the resident was receiving an antiplatelet, not an anticoagulant medication. She stated the MDS was an assessment of the resident's health status at a specific time and the information should be entered correctly. Record review of Resident #25's "Admission Record" revealed the facility admitted the resident on 10/2/18 with medical diagnoses that included Cerebral Ischemia.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 655	Continued From page 24 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to thoroughly develop a baseline care plan related to personal hygiene for (1) one of three (3) baseline care plans reviewed. (Resident #253) Findings include:	F 655	1. Fingernails were trimmed, filed, and cleaned for resident #253 by the Certified Nursing Assistant (CNA) on 2/12/2025. Resident #253 was shaved on 2/12/2025 by the CNA. Care plans were reviewed by Registered Nurse Assessment Coordinator (RNAC) on 2/12/2025 for resident #253 and updated to include	

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F 655	Continued From page 25 Review of the facility policy titled, "Baseline Care Plan Process," dated November 2017, revealed, "The baseline care plan is developed to include: the instructions needed to provide effective and person-centered care..." On 2/10/25 at 10:10 AM, an observation revealed Resident #253's fingernail beds to have a dark brown substance underneath them, and they were jagged in appearance. His facial hair was also observed to be unkept. On 2/11/25 at 1:53 PM, observation of Resident # 253 with Certified Nurse Assistant (CNA) #2 she confirmed the resident 's nails were jagged and had a brown substance under the nail beds. On 2/11/25 at 1:55 PM, an interview with Certified Occupational Therapist (COTA) she stated that she has Resident #253 on caseload for upper body therapy and confirmed his fingernails were dirty last week, and his facial hair was also unkept. A review of the Baseline Care plan for Resident #253 dated 1/29/25 revealed no interventions related to personal hygiene. In an interview with the Director of Nursing (DON) on 2/11/25 at 2:05 PM, she revealed after review of the baseline care plan for Resident # 253 she was unable to find where Activities of Daily Living (ADL) care was addressed and confirmed the care plan was not thoroughly developed to address personal hygiene. Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a	F 655	personal hygiene needs. The Baseline Care plan template was updated on 3/6/2025 to include an evaluation of the assistance needed for residents with ADL needs. 2. All residents requiring assistance nail care and shaving have the potential to be affected by this practice. 3. The Director of Nursing (DNS) assured nursing staff completed a 100% audit on 3/6/2025 of all residents to assess for dirty, jagged, or long nails. Any residents with long/jagged or dirty nails were immediately addressed. Any resident refusing nail care was care planned and charted as such. Any resident with personal choice for long nails was care planned. On 3/6/2025, the Director of Clinical Reimbursement provided education to the Registered Nurse Assessment Coordinator (RNAC) regarding compliance with the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual related to development of care plans. Going forward the baseline care plan will be reviewed during the morning clinical meeting by the Interdisciplinary Team (IDT) for each new admission to assure that ADL needs are addressed. 4. Going forward beginning on 2/17/2025, the DNS will audit the baseline care plan of five residents to ensure the presence of personal hygiene needs until the comprehensive care plan is developed. Audits will occur weekly for eight weeks, then monthly for one month. The results of the audits will be addressed in the Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 655	Continued From page 26 diagnosis of Traumatic Subdural Hemorrhage. Record review of Resident #253,s Section C of the Admission Minimum Data Set (MDS) dated 2/05/25 revealed the Brief Interview for Mental Status (BIMS) score was 9, indicating the resident had moderate cognitive impairment. Section: GG0130- I.) Personal hygiene-was coded partial/moderate assistance.	F 655	Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliancee. Any variance will be addressed immediately.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		3/14/25

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 656	Continued From page 27 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan for residents with personal hygiene needs (Resident #62, #74, #253), taking an antiplatelet medication (Resident #25), storage of respiratory equipment (Resident #82), and failed to implement a care plan for a resident on Enhanced Barrier Precautions (EBP) (Resident #11), Thromboembolic Deterrent (TED) (Resident #253), and receiving dialysis (Resident #8) for six (6) of 23 sampled residents. Residents #8, #11, #62, #74, #82, and #253 Findings Include Record review of facility policy titled, "Care Plans" with effective date of October 2021, revealed, "Care plans will be developed for all patients and	F 656	1. Care plans were reviewed by Director of Nursing (DNS) on 2/14/2025 for resident #8 and updated as needed. Resident #8 was assessed by the Assistant Director of Nursing (ADNS) on 2/14/2025 with no negative outcome. Resident #11 care plan was reviewed by Assistant Director of Nursing (ADNS) on 2/11/2025 and updated as needed. Resident #11 was assessed on 2/11/2025 by the nurse with no negative outcomes noted. Fingernails were trimmed, filed, and cleaned for resident #62 by the Nurse Practitioner (NP) on 2/12/2025. A care plan was developed by Registered Nurse Assessment Coordinator (RNAC) and implemented on 2/12/2025 to assure activities of daily living were addressed in accordance to the personal hygiene	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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F 656	Continued From page 28 residents based upon the RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change." Resident #8 A record review of Resident #8's care plan revealed the resident has an alteration in Kidney Function, evidenced by now requiring Hemodialysis. Interventions include obtaining pre- and post-dialysis vital signs every day and a written communication form with a review of weights and any changes in condition between the dialysis provider and center. A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 07/25/2012 with medical diagnoses of Chronic Kidney Disease, Stage 5, and Dependence on Renal Dialysis. A record review of Resident #8's "Order Review History Report" for 01/01/2025-01/31/2025 revealed a physician order for dialysis at the "proper name" dialysis center on Monday, Wednesday and Friday...Obtain pre- and post-dialysis vital signs one time a day every Monday Wednesday and Friday. An interview with Resident #8 on 2/11/25 at 8:54 AM confirmed that she is on dialysis and goes to the dialysis center on Monday, Wednesday, and Friday. She stated that don't always check her vital signs before and after. In an interview on 2/13/25 at 8:35 AM, the Director of Nurses (DON) confirmed she could	F 656	needs of resident #62. Care plan for resident #74 was reviewed by the RNAC on 2/12/2025 and implemented on 2/12/2025 to assure Activities of Daily Living were addressed in accordance with the personal hygiene needs of the resident. On 2/13/2025 Thrombo-embolic deterrent (TED) hose were applied to bilateral lower extremities of resident #253 by the nurse in accordance to the care plan. On 2/11/2025 the DNS cleaned the nebulizer, replaced the nebulizer tubing and ensured the nebulizer and tubing was stored appropriately from the floor for resident #82. This resident's care plan was updated on 2/12/2025 by the Director of Clinical Education to include that resident will place nebulizer machine on the floor. 2. All residents have the potential to be affected by this practice. 3. On 2/14/2025, the DNS assured nursing staff completed a 100% audit of all residents to assess for dirty, jagged, or long nails and facial/ear hair. Any residents identified with long/jagged dirty nails or facial/ear hair were immediately addressed. On 2/14/2025, the DNS completed an audit of all resident with TED hose and those receiving dialysis services. No other residents were affected. On 2/14/2025, the DNS provided education to the nursing department regarding implementation of dialysis care plan with an emphasis on ensuring communication with the dialysis center which includes nursing assessment and documentation of residents prior, during, and after dialysis sessions in	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 656	Continued From page 29	F 656		

not find any vital sign documentation for Resident #8's dialysis communication for January. She revealed that those records would have been sent with the resident on her dialysis appointments and returned afterward. The communication records were to have vital signs and pertinent information for Resident #8, and because the communication records were not being done, the resident's dialysis care plan was not followed.

An interview on 2/13/25 at 9:10 AM with Licensed Practical Nurse (LPN) Medical Records confirmed that the last communication record sent to the dialysis was on 12/11/24.

A record review of the "Dialysis Communication Record" dated 12/11/2024 revealed a completed communication record between the facility and the dialysis center with nurse signatures. This review revealed there were no complete communication records for 01/2025.

Record review of the MDS Section C with an Assessment Reference Date (ARD) of 1/13/25 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.

Resident #11

Record review of Resident #11's care plan revealed a care plan for a pressure ulcer on left heel with intervention to administer treatments as ordered. Another care plan for stage one pressure wound to right heel with intervention for treatments as ordered. Resident had a care plan for an unstageable pressure ulcer to the sacrum with an intervention to administer treatments as

accordance to the dialysis care plan. Education was completed on 2/27/2025 by the Director of Clinical Education (DCE) with staff on ensuring the use of enhanced barrier precautions (EBP) while performing care needs for residents identified requiring EBP according to the plan of care developed as EBP was an expected standard of practice. Any resident refusing nail care or facial hair removal or trimming was care planned and charted as such. Any resident with personal choice for long nails or facial hair was care planned. Education completed on 2/28/2025 with staff on Activities of Daily Living (ADL) to assure understanding and importance of checking resident appearance, nails, hair and overall grooming needs in accordance to the care plan by the DCE. Education was conducted by the DCE on 2/28/2025 with the nursing department regarding standards of care and following physician orders to include application of TED hose in accordance to the care plan. Education was completed by the DCE on 2/28/2025 to assure staff understanding of storage of nebulizers and nebulizer tubing in accordance to the care plan. Beginning 2/14/2025, the DNS will ensure that care plans of resident who receive hemodialysis services are developed and implemented according to resident assessment. Beginning 2/12/2025, the DNS will ensure that residents identified as requiring EBP have care provided in accordance with the plan of care. Beginning 2/14/2025, the Director of Nursing will ensure that each resident

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 656	Continued From page 30 ordered. Another care plan was for an infection related to wound infection with intervention administer antibiotics and treatment as ordered. An observation of Resident #11's pressure wound care completed by Licensed Practical Nurse (LPN) #1 and assisted by CNA #7 on 2/12/25 at 2:45 PM, revealed EBP was not followed when gowns were not worn during all of the wound care. An interview on 2/12/25 at 3:15 PM with the Director of Nursing (DON) revealed the care plan was developed and specified administer treatments as ordered for wound care. She stated enhanced barrier precautions (EBP) was part of the wound care guidelines and it was not listed as a separate intervention since it was included as an expected step in the wound care process. She confirmed that since enhanced barrier precautions were not properly used, the care plan for treatments as ordered was not followed. During an interview on 2/13/25 at 9:30 AM, MDS Coordinator #2 revealed this resident had a wound care plan developed to administer treatments as ordered and this automatically included the use of EBP. She stated the care plan was not followed as required. Record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 4/28/21. Diagnoses included Protein Calorie Malnutrition and Polyneuropathy. Record review of Resident #11's Significant Change in Status MDS with ARD of 1/15/25 revealed a BIMS score of 9 which indicated the	F 656	received nail care and facial hair needs in accordance of the care plan. If the resident refuses care, a notation will be added to the progress notes along with the tendency to refuse care noted in the care plan. Beginning 2/14/2025, the Director of Nursing will ensure that care plans of residents with orders for TED hose implemented according to resident care plan. On 3/3/2025 The Director of Clinical Reimbursement provided education to the Registered Nurse Assessment Coordinator regarding compliance with the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual related to development of care plans. 4. Beginning 3/3/2025, the Director of Nursing and Administrator will audit ten resident's care plans to assure care plans of residents receive dialysis or need assistance with nail or facial hair care,EBP, and TED hose are complete, revised as needed, and implemented. Audits will occur weekly for eight weeks, then monthly for one month. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 656	Continued From page 31	F 656		

resident had a moderate impairment cognitively.

Resident #62

Review of a care plan for Resident #62 titled, "Nursing Kardex," revealed no interventions related to personal hygiene.

On 2/11/25 at 1:30 PM, observation with Certified Nurse Assistant (CNA)#3 revealed that Resident #62's nails were long with a dark brown substance under them. She confirmed the residents nails needed clipping and cleaning.

On 2/11/25 at 2:09 PM, in an interview with the DON she revealed after review of the Kardex care plan for Resident #62 that there was not a care plan developed regarding personal hygiene.

In an interview with MDS Nurse on 2/12/25 at 2:40 PM, she revealed the purpose of the care plan is to let the staff know the type of care and services the resident requires and confirmed that the care plan is not thoroughly developed, the resident may not get the services they need.

Review of the "Admission Record" revealed the facility admitted Resident #62 on 8/23/23 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction.

Record review of Resident #62's Section C of the MDS dated 11/21/24 revealed the BIMS score was 13, indicating the resident was cognitively intact. Section: GG0130- I.) Personal hygiene-was coded setup or clean-up assistance.

Resident #253

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 656	Continued From page 32	F 656		

Review of a care plan for Resident #253 titled, "Nursing Kardex," initiated on 1/31/25, revealed, Interventions: "TED hose - apply every am (morning) and remove every pm (night) due to orthostatic blood pressures."

Record review of a physician's order dated 1/30/25 for Resident #253 revealed, "TED-(thromboembolic deterrent) hose - apply every am (morning) and remove every pm (night) due to orthostatic blood pressure."

On 2/11/25 at 2:05 PM, during an interview with the DON she confirmed after review of the care plan related to the use of the TED hose for Resident #253 the care plan was not being implemented when staff did not apply the hose as ordered.

In an observation with LPN #3 on 2/11/25 at 2:10 PM, of Resident # 253 she confirmed the resident was not wearing TED hose.

An interview Physical Therapy Assistant (PTA) on 2/12/25 at 2:08 PM she revealed she has seen Resident # 253 several times over the past two weeks for physical therapy of the lower body and confirmed she had not seen the resident wearing TED hose until today.

In an interview with the MDS Nurse on 2/12/25 at 2:40 PM, she revealed the purpose of the care plan is to let the staff know of the type of care and services the residents requires.

Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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F 656	Continued From page 33	F 656		

Record review of Resident #253's Section C of the MDS dated 2/05/25 revealed the BIMS score was 9, indicating the resident was severely cognitively impaired. Section: GG0130- H.) putting on/taking off socks and shoes was coded as dependent (helper does all the effort).

Resident #74

Record review of Resident #74's "Care Plans" revealed a care plan for Activities of Daily Living (ADL's) was not developed.

On 2/10/25 at 10:45 AM, an observation revealed Resident #74 had visible gray hairs extending from both ears that were approximately one-half (1/2) inch in length. This observation also revealed the resident's fingernails were approximately one-fourth (1/4) inch in length, jagged and had a brown substance under the nail beds.

On 2/10/25 at 1:29 PM, an interview with the Memory Care Unit Coordinator confirmed Resident #74 needed his nails trimmed and cleaned and had long ear hair.

An interview with the MDS Nurse on 2/12/25 at 9:20 AM, confirmed Resident #74 did not have an ADL care plan. She revealed the purpose of having the care plan was so that staff knew how to care for the residents.

Record review of the Admission Record revealed the facility admitted Resident #74 on 11/30/23 with a medical diagnosis that included Cerebral Infarction.

Resident #82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34	F 656		

Record review of Resident #82's care plan revealed a care plan for storage of respiratory equipment was not developed for the staff to follow.

On 2/10/25 at 11:05 AM, during the initial tour Resident #82's respiratory treatment nebulizer was observed on the floor next to the resident's bed. The tubing and mask were in a bag on top of the nebulizer. The resident stated he had lung issues and received treatments several times a day.

An interview with the Director of Nursing (DON) on 2/11/25 at 3:10 PM, revealed a care plan provided staff with information on the daily care and preferences for each resident. She confirmed the facility failed to develop a care plan for proper storage of respiratory equipment.

During an interview on 2/12/25 at 9:10 AM, Minimum Data Set (MDS) Coordinator #1 revealed a care plan guides the needed care and preferences for each resident and she was responsible for developing the care plans. She confirmed the facility failed to develop a care plan for the proper storage of Resident #82's respiratory nebulizer equipment.

Record review of Resident #82's "Admission Record" revealed the facility most recently admitted the resident on 1/23/25 with medical diagnoses that included Wedge Compression Fracture of Fourth and Fifth Lumbar Vertebra, Malignant Neoplasm of Bronchus or Lung, Emphysema, and Chronic Obstructive Pulmonary Disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 35 Record review of Resident #82's admission MDS with an ARD of 1/30/25 revealed a BIMS of 12 which indicated the resident had a moderate cognitive impairment.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene for three (3) of 23 residents reviewed for Activities of Daily Living (ADL) care. Resident #62, #74 and #253. Findings include: Review of the facility policy titled, "ADL's (activities of daily living)," dated August 2021, revealed, "Policy: Ensure ADLs are provided in accordance with accepted standards of practice. ... ADLs-(hygiene-grooming)..." Resident #62 An observation and interview on 2/11/25 at 11:00 AM, revealed Resident #62's fingernails to be approximately 1/2 (one-half) inch long past the tips of the fingers, dirty in appearance with a dark brown substance under the nail beds. Resident #62 stated he would like to have them trimmed and confirmed he did not like them long.	F 677	1. Fingernails were trimmed, filed, and cleaned for resident #62 on 2/11/2025 by the Nurse Practitioner and residents #253, and #74 by the Certified Nursing Assistant (CNA) on 2/14/2025. Resident #253 was shaved on 2/14/2025 by the CNA. Resident #74 was provided hair trimming extending from his ears on 2/11/2025 by CNA. The nurse assessed resident #62 on 2/11/2025 and assured the nails were trimmed and cleaned. Care plans were reviewed by Registered Nurse Assessment Coordinator (RNAC) on 2/12/2025 for all three residents and updated as needed. 2. All residents requiring assistance nail care and facial hair have the potential to be affected by this practice. 3. On 2/17/2025, The Director of Nursing (DNS) assured nursing staff completed a 100% audit on all residents to assess for dirty, jagged, or long nails and facial hair. Any residents identified with long/jagged or dirty nails were immediately addressed. Any resident refusing nail care or facial	3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 677	Continued From page 36 An observation on 2/12/25 at 1:30 PM, with Certified Nurse Assistant (CNA)#3 confirmed that Resident #62's nails were very long and dirty with a dried dark brown substance under the nail beds. She stated it appeared that the resident had not had nail care in a very long time. In an interview with the Director of Nursing (DON) on 2/12/25 at 2:09 PM, she revealed that if the residents were not getting personal hygiene it could lead to the spread of bacteria and skin concerns. She confirmed that Resident #62's nails should have already been cleaned and trimmed. Review of the "Admission Record" revealed the facility admitted Resident #62 on 8/23/23 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction. Record review of Resident #62's Section C of the Annual Minimum Data Set (MDS) dated 11/21/24 revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section: GG0130- I.) Personal hygiene-was coded setup or clean-up assistance. Resident #253 An observation on 2/10/25 at 10:10 AM, revealed Resident #253's fingernail beds to have a dark brown substance underneath them, and they were jagged in appearance. His facial hair was also observed to be unkept. An observation on 2/11/25 at 1:30 PM, revealed Resident# 253 to have a brown substance under his fingernail beds, and the fingernails remained jagged in appearance.	F 677	hair removal was care planned and charted as such. Any resident with personal choice for long nails or facial hair was care planned. Systemic changes implemented on 2/17/2025 to avoid this nail care and facial concerns included implementing daily environmental rounds check list to include observation of nails. Any resident with long/jagged or dirty nails or unkempt facial hair should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the administrator on 3/6/2025 with team members regarding updated environmental rounds along with implementation. Education completed on 2/28/2025 with staff on Activities of Daily Living (ADL) to assure understanding and importance of checking resident appearance, nails, hair, and overall grooming needs by the Director of Clinical Education. 4. On 2/17/2025, the Director of Nursing began an audit of a minimum of five residents weekly x four weeks then monthly for an additional two months to assure that nails are clean and trimmed and facial hair trimmed in accordance with the resident's wishes. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 677	Continued From page 37	F 677		

An observation of Resident #253 on 2/11/25 at 1:53 PM, with CNA #2 confirmed the resident's nails were jagged and had a brown substance under the nail beds.

In an interview with the Certified Occupational Therapist (COTA) on 2/11/25 at 1:55 PM, she stated that she has Resident #253 on caseload for upper body therapy and confirmed his fingernails were dirty last week and his facial hair was also unkept.

In an interview with the DON on 2/11/25 at 2:05 PM, she confirmed that Resident #253 should have had nail care and that staff failing to provide personal hygiene care for any resident could lead to skin concerns and spread of bacteria.

Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.

Record review of Resident #253's Section C of the Admission MDS dated 2/05/25 revealed the BIMS score was 9, indicating the resident was moderately cognitively impaired. Section: GG0130- I.) Personal hygiene-was coded partial/moderate assistance.

Resident #74

An observation on 2/10/25 at 10:45 AM, revealed Resident #74 sitting in his wheelchair in the hallway with long gray hairs extending from both of his ears, approximately one-half (1/2) inch in length. His fingernails on both hands measured approximately one-fourth (1/4) inch in length and jagged with a brown substance underneath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 38 An interview with the Memory Care Unit Coordinator on 2/10/25 at 1:29 PM, confirmed Resident #74 had long, jagged nails. She revealed the aides were responsible for cutting, cleaning, and filling them with showers. She revealed the resident could scratch himself and cause a skin injury. She stated the barber was responsible for trimming the resident's ear hair and explained he trimmed it when he had time but had not been there recently. Record review revealed the facility admitted Resident #74 on 11/30/23 with a medical diagnosis that included Cerebral Infarction.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for treating skin concerns (Resident #303) and application of TED (thromboembolic deterrent) compression hose for two (2) of 23 sampled residents. Resident #253 and #303	F 684	1. Thrombo-embolic deterrent (TED) hose were applied to bilateral lower extremities of resident #253 by the nurse on 2/13/2025. Resident #303 was assessed by the nurse and a treatment order was obtained for the skin tear on 2/13/2025. This resident's careplan was updated to reflect the new plan of treatment. Resident #303 and #253 were	3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 Findings include: Review of the facility policy titled "Skin Care Guideline" unrevised, revealed under, "Purpose: To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity." A review of a statement on facility letterhead titled, "Standards of Practice," revealed, "The expectation set forth by (Proper Name) management is that nurses comply with current standards of practice in terms of following physician's orders. This includes following orders for application of medical devices such as TED hose." Resident #253 Record review of a physician's order dated 1/30/25 for Resident #253 revealed, "TED hose - apply every am (morning) and remove every pm (night) due to orthostatic blood pressures." An observation on 2/10/25 at 10:10 AM, revealed Resident #253 lying in the bed with regular socks on his feet. An observation on 2/11/25 at 1:30 PM revealed no TED hose on Resident #253's legs and none in the resident's room. An observation of Resident # 253 on 2/11/25 at 1:53 PM with Certified Nurse Assistant (CNA) #2 revealed she was unaware of any TED hose and had not seen them on the resident. In an observation and interview with Licensed	F 684	assessed by the Director of Nursing (DNS) on 2/13/2025. There were no negative outcomes. 2. All residents have the potential to be affected by the deficient practice. 3. Nursing staff conducted 100% skin audit completed on 2/21/2025 of all residents to assess for any skin integrity concerns. There were no other residents identified with new skin concerns. On 2/21/2025 the DNS audited residents with physicians orders for TED hose and verified placement. There were no other residents identified. Education was conducted by the Director of Clinical Education (DCE) on 2/28/2025 with the nursing department regarding standards of care and following physician orders to include application of TED hose. Education completed on 2/28/2025 with nurses on identification and obtaining orders from medical providers for addressing skin impairment concerns by the DCE. 4. Going forward, beginning on 2/17/2025 the DNS or team member will review daily for residents with identified skin impairment concerns to assure for presence of a treatment order. Beginning 2/17/2025, the Director of Nursing will audit residents with orders for TED hose and ensure application. This audit will occur five times weekly for four weeks, then monthly for two months. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 Practical Nurse (LPN) #3 on 2/11/25 at 2:10 PM, she revealed after review of Resident # 253's physician's orders, she confirmed the resident had an order for TED hose. An observation of Resident # 253 at this time with LPN #3 she confirmed the resident was not wearing TED hose and that if the resident did not wear the hose as ordered it could lead to increased episodes of orthostatic hypotension. An interview Physical Therapy Assistant (PTA) on 2/12/25 at 2:08 PM she revealed she has seen Resident # 253 several times over the past two weeks for physical therapy of the lower body and confirmed she had not seen the resident wearing TED hose until today. Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage. Record review of Resident #253's Section C of the MDS dated 2/05/25 revealed the BIMS score was 9, indicating the resident was moderately cognitively impaired. Section: GG0130- H.) putting on/taking off socks and shoes was coded as dependent (helper does all the effort). Resident #303 An observation on 2/10/25 at 10:50 AM, revealed Resident #303 sitting in a recliner in the activity room. Two beige foam dressings observed on his left elbow with a moderate amount of brown drainage the size of 2 quarters. There was no date on the bandage. Record review of Resident #303's "Order Summary Report" revealed there were no orders	F 684	assure continued compliance. Any variance will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

for any skin concerns.

An observation of Resident #303 on 2/13/25 at 8:56 AM, revealed two brown foam bandages observed to the left elbow with no date.

An observation and interview with Registered Nurse (RN) #3 on 2/13/25 at 9:02 AM, after removal of the two dressings on Resident #303's left arm revealed, a skin tear to the left upper arm above the elbow with intact skin and a skin tear to the elbow with no intact skin that was circular in appearance. A moderate amount of whitish drainage was present. RN #3 revealed she was not aware that the resident had skin tears. She revealed the resident did have a fall after admission and could have gotten a skin tear then. She confirmed the resident did not have an order for treatment and explained she had no idea how long the bandage had been there. RN #3 confirmed Resident #303 could get an infection or a delay in healing due to lack of treatment and monitoring.

Record review of the "Progress Notes" dated 2/1/25 for Resident #303 revealed, "Resident rolled out of bed and hit head on garbage can and cut above eyebrow, skin tear on left hand and left elbow." Also revealed, "The areas were cleaned and steri strips put on them."

An interview with Registered Nurse (RN) #1 on 2/13/25 at 11:02 AM, revealed without proper monitoring and treatment of Resident #303's skin tears, they could worsen and deteriorate and become infected.

Record review of the "Admission Record" revealed the facility admitted Resident #303 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42 1/30/25 with a diagnosis that included Acute Kidney Injury.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to provide ongoing communication documentation with the hemodialysis center for one (1) of one (1) residents receiving hemodialysis reviewed. Resident #8. Findings include: Record review of the facility policy titled, "Outpatient Dialysis Services and Compensation" undated, revealed, "...d When a resident is transferred to the Dialysis Unit for Services, the Facility shall: (i) transmit resident information necessary for Contractor's delivery of Services and in accordance with applicable law; (ii) make resident records available to Contractor as necessary for provision of Services and in accordance with applicable law; ...5. Patient Records. Facility and Contractor shall each prepare and maintain records concerning Facility's residents receiving Services under this Agreement, in accordance with applicable federal and state laws, regulations and program guidelines..."	F 698	1. Resident #8 was assessed on 2/12/25 by the Registered Nurse. There were no negative outcomes observed. There are no other residents receiving dialysis identified. 2. All residents receiving dialysis services are at risk for the deficient practice. 3. On 2/14/25, the Director of Nursing provided education to nurses on completing dialysis communication forms to ensure communication with the dialysis center which includes nursing assessment and documentation of residents prior, during, and after dialysis sessions. Beginning on 2/17/25 the Health Information Management Coordinator (HIM-C) will ensure communication sheets are present in the resident medical record. Education will be provided by Director of Clinical Education (DCE)/designee for all newly hired licensed nursing staff on dialysis communication. 4. Beginning 2/17/25, the Director of Nursing will audit all residents receiving	3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 43 A record review of Resident #8's "Admission Record" revealed the resident was admitted to the facility on 07/25/2012 with medical diagnoses of Chronic Kidney Disease, Stage 5, and Dependence on Renal Dialysis. A record review of Resident #8's "Order Review History Report" for 01/01/2025-01/31/2025 revealed a physician order for "...dialysis at the "proper name" dialysis center on Monday, Wednesday and Friday...Obtain pre-and post dialysis vital signs one time a day every Monday, Wednesday and Friday." An interview with Resident #8 on 2/11/25 at 8:54 AM, revealed she is on dialysis and goes to the dialysis center on Monday, Wednesday, and Friday. She revealed that sometimes the nurse checks her vital signs before she leaves, but it doesn't happen all the time and they don't check her vital signs when she returns from dialysis. She revealed she doesn't take any paperwork with her to give to the dialysis center. An interview on 2/12/25 at 2:26 PM, Minimum Data Set (MDS) Nurse #1 revealed that Resident #8 is on dialysis. However, with the quarterly MDS with an Assessment Reference date (ARD) of 1/13/25, we were not able to bill for her because we did not have the communication sheets completed for her which would reflect her vital signs for pre and post-dialysis treatment. She revealed for whatever reason they were just not being completed. She revealed that we had to pay back money with their last case-mix and we were informed by our corporate office that we could not bill for the dialysis services if the communication sheets were not filled out, so she	F 698	dialysis services to ensure dialysis communication completion and presence in the medical record. Audits will occur weekly for eight weeks, then monthly for two months. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 44	F 698		

did not select dialysis on the quarterly MDS.

During an interview on 2/13/25 at 8:24 AM, Licensed Practical Nurse (LPN) #3 revealed she is the nurse for Resident #8, and the resident went out yesterday for dialysis. LPN #3 revealed that she hadn't completed a communication sheet to the dialysis facility. LPN #3 stated, "Is that something I need to do?"

In an interview on 2/13/25 at 8:35 AM, the Director of Nurses (DON) confirmed she could not find any dialysis communication records for January. She stated, she was "unaware they were not being completed." She revealed that communication records are essential for coordinating and collaborating between the facility and the dialysis center. The communication records were to have vital signs and pertinent information for Resident #8.

During an interview on 2/13/25 at 8:56 AM, the Administrator (ADM) revealed that the floor nurses should complete the communication paperwork for the resident before and when returning from dialysis. She revealed that she was unaware that the communication records were not being completed, and that the facility was not able to bill for the dialysis for the MDS completed with an ARD of 1/13/25. The ADM confirmed that the communication between the facility and the dialysis center must be ongoing for the continuation of care for Resident #8.

An interview on 2/13/25 at 9:10 AM, with the Medical Records nurse revealed that the last communication record sent to the dialysis was on 12/11/24. She revealed that everyone knows this is an ongoing issue. She revealed that she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 45 tried to complete the paperwork when she noticed the floor nurses were not doing it. A record review of the "Dialysis Communication Record" dated 12/11/2024 revealed a completed communication record between the facility and the dialysis center with nurse signatures. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date of 1/13/25 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. Section I Active Diagnoses revealed Resident #8 was marked for Renal Insufficiency, Renal Failure, or End-Stand Renal Disease (ESRD).	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 46 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain a system of medication records that enables accurate reconciliation and accounting for all controlled medications for (1) one of (3) three narcotic storage areas reviewed. Findings include: Review of the facility policy titled, "Controlled Substance Accountability Guideline," revealed, Chapter 2: Controlled Substances (General): Medication nurse on duty shall maintain possession of the keys to controlled substances. ... Chapter : Change of Shift Reconciliation: Two licensed nurses, typically the nurse arriving, and the nurse departing from duty, are to conduct the reconciliation of patient specific controlled substances and sign a signature attesting to the accuracy of the count. ... An observation during medication administration on 2/12/25 at 8:30 AM, on A-Hall with Licensed Practical Nurse (LPN)#1 revealed LPN #1 give the medication cart keys to the Medical Records	F 755	1. On 2/12/25, the Director of Nursing (DNS) ensured the narcotic medication was secured in a permanently affixed compartment in the refrigerator. Education was provided on 2/12/25 to LPN#1 and LPN#2 on the end of shift controlled substance reconciliation process by the Director of Clinical Education (DCE). LPN#1 was educated on 2/12/25 by the DCE on ensuring possession of medication cart and medication storage room keys at all times unless a reconciliation has been performed for another nurse to assume possession of the keys. 2. All residents of the facility receiving a controlled medication have the potential to be affected by the practice. 3. A controlled medication reconciliation was completed on 2/12/25 by the DNS to ensure all narcotic medications were present and stored appropriately. All medications were accounted for and stored in permanently affixed compartment in the refrigerator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

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F 755	Continued From page 47 nurse to get a medication out of the medication room for him. In an interview with LPN #1 on 2/12/25 at 8:35 AM, he confirmed that he gave the medical records nurse the keys to the medication room that included the keys to the medication refrigerator that stored narcotics. He then revealed he was not sure if there were any narcotics in the medication room refrigerator. He stated that when the off going nurse, LPN #2, and he counted the narcotics they only counted the narcotics on the medication cart and never checked the refrigerator. An observation of the A hall medication room refrigerator narcotic box with LPN #1 revealed three boxes of Lorazepam concentrate in the medication refrigerator. An observation of the narcotic book with LPN #1 revealed the narcotic sheets for the three bottles of Lorazepam were in the narcotic book. LPN #1 confirmed he should have counted the narcotics in the refrigerator, and stated failing to do so could lead to missing narcotics and inaccurate narcotic count. In a phone interview with LPN #2 on 2/12/25 at 7:10 PM, she confirmed that she and LPN #1 only counted the narcotics on the medication cart. When asked why she did not count the narcotics in the refrigerator, she stated, "I don't know, we just didn't." She confirmed she was aware of the Lorazepam in the refrigerator because there were narcotic sheets on the narcotic book, and she counted at the beginning of her shift. In an interview with the Director of Nurses (DON) on 12/13/25 at 8:00 AM, she confirmed the nurses should reconcile all narcotics at the beginning and end of each shift to ensure an	F 755	On 2/12/25, the Pharmacy Consultant completed education to nursing staff on end of shift reconciliation process and on ensuring possession of medication cart and medication storage room keys at all times unless a reconciliation has been performed for another nurse to assume possession of the keys. 4. To monitor the performance to assure compliance, the Director of Nursing Services or pharmacy representative or team member will observe nursing staff perform end of shift reconciliation twice weekly x four weeks beginning on 2/17/25, then monthly x three months. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 755	Continued From page 48 accurate account of all narcotics. She also confirmed that the nurse should never have given their narcotic keys to any other staff once they accepted responsibility for them. The DON then stated failing to reconcile all narcotics could lead to missing narcotics and possible diversion. In an interview with the Medical Records nurse on 2/13/25 at 11:00 AM, she confirmed she should have not accepted LPN#1's keys that included the key to the refrigerator narcotic box because she did not count those narcotics.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		3/14/25

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F 758	Continued From page 49 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure a PRN (as needed) psychotropic medication had a stop date for one (1) of six (6) resident medications reviewed. Resident #69 Findings Include: The facility provided a statement on letterhead, "(Proper name of the facility) follows the guidance of CMS (Centers for Medicare and Medicaid Services) as psychotropic medications ordered for PRN (as needed) usage shall not exceed past 14 days without further medical provider	F 758	1. An order from the Nurse Practitioner (NP) to discontinue the PRN (as needed) anxiolytic medication for resident #69 was obtained by the Director of Nursing (DNS) and executed on 2/11/25. Resident #69 was assessed by the NP on 2/11/25 with no negative findings for this resident. Education was provided on 2/28/25 to the NP by the Director of Clinical Education (DCE) that all PRN psychotropic medications ordered will not exceed fourteen days without further medical provider assessment for continuation of the medication for each reinstatement of	

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F 758	Continued From page 50 assessment in the facility for continuation of medication for each reinstatement of the order." Record review of Resident #69's February 2025 Medication Administration Record (MAR) revealed an order dated 12/17/24, "Ativan (antianxiety) Oral Tablet 1 MG (milligram) (Lorazepam) give 1 tablet by mouth every 24 hours as needed for anxiety and agitation" with no stop date. An interview with Registered Nurse (RN) #4 on 2/11/25 at 3:42 PM, confirmed Resident #69's Ativan order did not have a stop date. She revealed the resident usually took it on his shower days because he became combative. An interview with the Director of Nursing (DON) on 2/11/25 at 4:15 PM, revealed the purpose of having a stop date on an as needed (PRN) psychotropic medication was for the doctor to re-evaluate the need for the medicine. Record review of the "Admission Record" revealed the facility admitted Resident #69 on 9/30/21 with medical diagnoses that included Unspecified Dementia.	F 758	the order. 2. All residents receiving psychotropic on an as needed basis are at risk for the deficient practice. 3. An audit was completed on 2/28/25 by the DCE to ensure any resident receiving a PRN (as needed) psychotropic medication had a discontinue date not exceeding fourteen days. There were no other residents identified. Education was completed on 3/4/25 with licensed nursing staff by the DNS for obtaining an order for discontinuation on all PRN psychotropics and use to not exceed fourteen days without further medical provider assessment for continuation of medication for each reinstatement of order. Education will be provided by Director of Clinical Education (DCE) or team member for all newly hired licensed nursing staff on regulation of PRN (as needed) psychotropic medication use with additional training as needed to ensure all PRN (as needed) psychotropic medication are discontinued within fourteen days. 4. Going forward, the Interdisciplinary Team (IDT) will review daily any new PRN psychotropic medication ordered has a stop date not exceeding fourteen days. DNS or team member will audit all PRN psychotropic medications one x weekly for one month, then once monthly for two months beginning on 2/28/25. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any	

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F 758	Continued From page 51	F 758	variance will be addressed immediately.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based staff interview, record review, and facility policy review the facility failed to store controlled drugs in a locked permanently affixed compartment for storage as evidenced by an unopened box of Lorazepam Concentrate 30 milliliters sitting on a shelf in the refrigerator among other non-narcotic medications for one (1)	F 761	1. On 2/12/2025, the Director of Nursing (DNS)ensured the narcotic medication was secured in a permanently affixed compartment in the locked refrigerator which was located in the locked medication room. Education was provided by the DNS on 2/12/2025 to	3/14/25

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F 761	Continued From page 52 of three (3) narcotics refrigerator storage observed. Findings include: Review of the facility policy titled, "Medication Storage," last reviewed 4/23, revealed, " ...Procedure ...Controlled medications---stored in a separately locked, permanently affixed compartment designated for that purpose ..." An observation of the A hall medication room refrigerator narcotic box with Licensed Practical Nurse (LPN) #1 on 2/12/25 at 8:35 AM, revealed an unopened box of Lorazepam Concentrate 30 milliliters sitting on a shelf in the refrigerator among other non-narcotic medications not in a secure affixed box. LPN #1 confirmed the Lorazepam was not stored appropriately and should have been in the secured lock box in the refrigerator. In an interview with the Director of Nursing (DON) on 2/13/25 at 8:00 AM, she confirmed the Lorazepam Concentrate that was stored unsecured should have been in the affixed lock box in the refrigerator. She stated the secure lock box was full, and she believed that is why it was just placed on the refrigerator shelf. She then stated staff should have informed her of the problem. Furthermore, she also revealed that improper storage of narcotics could lead to missing narcotics and possible diversion.	F 761	LPN#1 to assure understanding of correct controlled medication storage. 2. All residents of the facility receiving a controlled medication have the potential to be affected by the practice. 3. A controlled medication reconciliation was completed on 2/12/2025 by the DNS to ensure all narcotic medications were present and stored appropriately. All medications were accounted for and stored behind double locks in a permanently affixed compartment in the refrigerator. On 2/13/2025, the Director of Clinical Education (DCE) completed education to nursing staff regarding correct storage of narcotic medications to ensure the drugs and biologicals are properly stored in the locked medication cart or in the permanently affixed compartment in the refrigerator. 4. To monitor the performance to assure sustainability, the Director of Nursing Services or pharmacy representative, or team member will conduct observations daily x four weeks beginning on 2/17/2025, then monthly x 3 months to ensure the drugs and biologicals are properly stored in the locked medication cart or in the permanently affixed compartment in the refrigerator. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes	F 806		3/14/25

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F 806	Continued From page 53 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to honor a resident's beverage preference during dining for two (2) of three (3) residents reviewed for dining observation. Resident #13 and Resident #303 Findings Include: Review of the facility policy titled "Dining and Food Preferences" with a revision date of 9/17, revealed "Policy Statement: Individual dining, food, and beverage preferences are identified for all residents/patients." An observation of Resident #13 on 2/10/25 at 11:44 AM, revealed she was lying in bed. Registered Nurse (RN) #4 entered the resident's room with her meal tray. The resident voiced she wanted to eat in the dining room and wanted a large glass of tea. RN #4 explained to the resident she could only have a small glass of tea because of the caffeine and stated, "You can have a small glass of tea and some water, or you'll be climbing the wall." A large glass of tea	F 806	1. On 2/18/2025, the Dietary Services Manager met with resident #13 to update dietary preferences regarding the desire to receive a larger serving of sweet tea with meals. On 2/18/2025, the Dietary Services Manager met with resident #303 to update dietary preferences regarding the desire to receive coffee with meals. Tray tickets were updated at that time. Education was provided 3/5/2025 to RN#4 by the Administrator to assure resident's choices and preferences were provided. 2. All residents have the potential to be affected. 3. Beginning 2/18/2025 and completed by 2/20/2025, Dietary staff interviewed all residents to determine preferences. All resident tray tickets was updated at that time. On 2/27/2025, the Administrator began education with direct care staff regarding resident choice to assure resident's choices and preferences are provided when requested. 4. Beginning 2/24/2025, the Administrator or team member will conduct resident	

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F 806	Continued From page 54 was not provided. An observation of Resident #13 during the lunch meal on 2/11/25 at 11:52 AM, revealed the resident was eating in the dining area and had a small 120 milliliter (ML) glass of tea and water. An observation of Resident #303 during the lunch meal on 2/11/25 at 11:55 AM revealed the resident was sitting at the dining table and requested a cup of coffee. Registered Nurse (RN) #4 replied, "We only get coffee with breakfast." The coffee was not provided. An interview with Resident #303 on 2/11/25 at 1:24 PM, revealed he liked coffee in the morning, and voiced he could drink it all day. An interview with the Memory Care Coordinator on 2/11/25 at 1:29 PM, confirmed the residents should have their preferences honored. She revealed that if a resident requested something and if possible, the staff should provide it. She confirmed she overheard Resident #303 request coffee at lunchtime and revealed the nurse should have gone to get the coffee. An interview with RN #4 on 2/11/25 at 1:42 PM, revealed she did not give Resident #13 a large glass of tea because her family did not want her to have it due to the caffeine. She confirmed the resident had the right to request the things in life that she liked. She confirmed Resident #303 should have been given coffee when he requested it at lunch, as this was his preference. An interview with the Administrator on 2/12/25 at 2:18 PM, confirmed the residents have a right to their preference. She explained the kitchen has	F 806	interviews of ten residents weekly x four weeks then monthly x two to assure resident preferences are acknowledged and provided. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 806	Continued From page 55 coffee available throughout the day for the residents and stated the staff should get the things the residents request. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 11/02/23 with medical diagnoses that included Schizophrenia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #13 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #303 on 1/30/25 with a medical diagnosis that included Acute Kidney Failure. Record review of the 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/06/25 revealed under section C, a BIMS summary score of 3, which indicated Resident #303 was severely cognitively impaired.	F 806		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		3/14/25

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F 867	Continued From page 56 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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F 867	Continued From page 57	F 867		

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 867	Continued From page 58 projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review, and facility policy review, the facility Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification survey of 10/19/23. This was for deficiencies re-cited during a recertification and complaint survey on 2/13/25. The re-cited deficiencies included F 584, F 656, F 677, F 684, F 761, and F 880. The continued failure of the facility during two state surveys indicates a pattern of the facility to sustain an effective QAPI program. This was for six (6) of 18 deficient practice citations.	F 867	1. The Administrative Staff, Regional Director of Clinical Operations (RDCO), Chief Nursing Officer (CNO), and the Regional Vice President (RVP) met on 2/21/2025 to review the survey findings of the survey including a review of our repetitive citations from past surveys. Per direction of the RVP, the center developed a corrective action plan to include F584, F656, F677, F684, F761, and F880. The RVP educated the Administrator on the process for Quality Assurance and Improvement (QAPI) on 2/21/2025 to include identification of problems, root cause analysis, development of plans,	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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F 867	Continued From page 59 Findings Include: This citation is cross-referenced to: F 584, F 656, F 677, F 684, F 761, and F 880 Review of the facility policy titled "Quality Assurance and Performance Improvement" dated February 2017 revealed, "Purpose: QAPI is a data driven, proactive approach to improving the quality of life, care, and services in our centers. The activities of QAPI involve team members at all levels of the organization to identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor the effectiveness of our interventions. QAPI is consistent with our Services Standard: We continually strive to improve personal and company performance" ... During the recertification and complaint survey on 10/19/23 the facility was cited F 561, F 584, F 656, F 677, F 684, F 761, F 812, F 880. During the recertification and complaint survey on 2/13/25 the facility was cited F 550, F 576, F 584, F 604, F 623, F 641, F 655, F 656, F 677, F 684, F 698, F 755, F 758, F 761, F 806, F 867, and F 880. During an interview on 2/13/25 at 10:18 AM, the Administrator (ADM) revealed our EMBRACE rounds, which are checklist sheets assigned to all supervisory staff. She stated the goal of the program is to go out and catch the issues found and ensure they are corrected. She confirmed she feels like the staff finds deficient practices when they do the Embrace rounds, then stated,	F 867	monitoring and continued reevaluation. A Quality Assurance and Performance Improvement (QAPI) meeting was held on 2/27/2025 with the QAPI committee to address corrective actions going forward. 2. All residents have the potential to be affected by lack of an effective QAPI program. 3. Systemic changes going forward include the development of an over arching stabilization plan for the center to include detailed approaches for corrective action related to negative findings of the survey along with consideration of repetitive tags. Weekly meetings beginning 2/21/2025 will be held to include the RVP, CNO, RDCO, and the center leadership team to measure implementation of the plan and to offer support for success for a minimum of three months. The plan will be adjusted weekly based on outcomes and opportunities. Education to be provided to all team members by the Administrator on 2//27/2025 regarding QAPI to include our areas of opportunity addressed in the support plan. Audit tools will be developed to monitor F584 (dirty wheelchairs, Dirty/rusted overbed tables, wall/painting disrepair), F656 (development/implementation of comprehensive care plans), F677 (provision of care to meet ADLs with nail care and facial hair), F684 (Quality of Care - application of TED hose and lack of treatment order), F761 (secured medications), and F880 (Infection Control with emphasis on Enhanced Barrier Precautions).	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 867	Continued From page 60 "but the follow-up is not strong as it should be to ensure the problems are corrected." She also stated the facility had had a lot of turnover in staff including the Infection Control Nurse/ Educator resulting in the Embrace audits halting from November 2024 and restarted in January 2025. Furthermore, she revealed the facility recently hired a new Infection Control Nurse/ Educator on 2/11/25, and she hopes that that will help with addressing issues. During an interview with the Director of Nursing (DON) on 2/13/25 at 11:30 AM, she confirmed the facility had a lot of staff turnover the past few months, she then stated when the facility finds issues they audit and monitor the concerns for awhile, and then it just gets pushed to the side and there is no follow-up.	F 867	4. To assure continued compliance, beginning 3/13/2025, the Administrator will audit the compliance with corrective action plans by reviewing audit tools weekly for four weeks, and then monthly for two months for a total of three consecutive months. Any variance to success or lack of progression towards correction, the plan will be revised immediately.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 61 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 62 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by: 1) not having procedures in place to monitor and test the water source for Legionella's Disease which had the potential to affect all residents in the facility; 2) storing of respiratory equipment on the floor for Resident #82, and 3) not using required Enhanced Barrier Precautions (EBP) Resident #11 and Resident #157 for three (3) of 23 sampled residents. Findings include: Record review of facility policy titled, "Infection Control Guide", dated 2022, revealed, " ...In order to accomplish the primary goal of infection control, which includes preventing or reducing the risk of healthcare associated infections, an epidemiology plan needs to be designed to include the following oversight operations and responsibilities: ... cleaning and disinfecting equipment ... prevention of infections ...Enhanced Barrier Precautions recommendations is to consider expanding the use of PPE (Personal Protective Equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for	F 880	1. Education was completed on 2/12/2025 by the Director of Clinical Education (DCE) with Licensed Practical Nurse LPN#1 and Certified Nurses Assistant CNA#7 on enhanced barrier precautions (EBP) to assure use of appropriate personal protective equipment while performing care needs for residents. Resident #11 was assessed 2/11/2025 by the nurse and no negative outcome was noted. Education was completed by the Director of Clinical Operations on 2/11/2025 with RN#1 on enhanced barrier precautions to assure use of appropriate personal protective equipment while intravenous medications via a peripherally inserted central catheter. The resident was assessed by the Assistant Director of Nursing (ADNS) with no negative outcomes. On 2/11/2025 the Director of Nursing (DNS) cleaned the nebulizer, replaced the nebulizer tubing and ensured the nebulizer and tubing was stored appropriately from the floor for resident #82. This resident's care plan was updated on 2/12/2025 by the Director of Clinical Education (DCE) to include that the resident will be encouraged to place nebulizer on bedside table and not on the	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 63 transfer of MDROs (multidrug resistant organism) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, from nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infections or colonization..." Record review of facility policy titled, "Policies and Practices - Infection Control", dated 11/1/17, 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. ... The objectives of our infection control policies and practices are to: a. prevent, identify, detect, investigate, report and control infections in the center; b. maintain a safe, sanitary, and comfortable environment for team members, residents, volunteers, visitors, and the general public..." Record review of facility policy titled, "Legionnaires' Disease: Detection, Response, Prevention" with revision date of 2/2/17, revealed, "The Center will utilize sound clinical and infection control practices to quickly identify and treat any potential Legionnaires" related illnesses. ... This water management program will consist of the following... decide where 'control measures' should be applied and set limits, such as,	F 880	floor. An audit of all residents was completed on 2/11/2025 to determine appropriate signage needed for residents requiring enhanced barrier precautions by the DCE. Appropriate signage was immediately placed to the resident doors. Procedures will be put into place by 3/12/2025 to monitor and test the water source for Legionnaires disease that includes the adherence to CMS QSO-17-30 and consideration of the CDC tool kit, a water management plan that includes a facility risk assessment for legionella that identifies areas of the water system where Legionella could grow and spread, control measures to mitigate or eliminate the risk of Legionella development, recording and monitoring of the control measures and a testing protocol on water cultures for the presence of Legionella. 2. All residents have the potential to be affected by this practice. No additional residents were observed to be impacted as of 2/12/2025. 3. Education was completed by the DCE on 2/12/2025 to assure staff understanding and implementation of EBP and storage of nebulizers and nebulizer tubing. Going forward, the facility will conduct environmental rounds daily for observation of required EBP signage. Any missing signage will be immediately addressed and corrected. An in-service was conducted by the DCE on 2/27/2025 with team members regarding updated environmental rounds along with implementation. All new admits and readmits will be reviewed for need for	

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	255119	A. BUILDING _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 64 temperature levels, disinfectant levels, acceptable ranges, etc., establish ways to intervene when control limits are not met (corrective actions), verify that your program is running as designed and is effective, document and communicate all activities of your Water Management Program." During an interview with Maintenance #1 on 2/13/25 at 10:15 AM, he revealed that they changed shower heads in the facility monthly, flushed unused water sources, and flushed eye wash stations to prevent Legionella. He stated he did not keep logs on the measures he had in place, and he did not monitor them to ensure the measures used were effective. An interview with the Administrator on 2/13/25 at 10:30 AM revealed Legionella and other water borne illnesses were serious and could cause major health complications. She stated the water system should be checked and monitored to ensure the residents were safe from any potential illness and to ensure this and thinks the water should be tested to be certain the measures in place were effective. She confirmed that the facility failed to have documented monitoring of the preventative measures testing to ensure they maintain the water system safely. Resident #11 During an interview on 2/11/25 at 9:30 AM, Resident #11 stated she had a sore on her bottom and her feet and she was receiving treatment on them. An observation on 2/12/25 at 2:45 PM of wound care provided by Licensed Practical Nurse (LPN) #1 and assisted by Certified Nursing Assistant	F 880	EBP signage by the DNS and DCE or team member. Control measures will be added by 3/12/2025 to the centers computerized maintenance management system (TELS) so they can be recorded and monitored. In service on water management plan including control measures will be provided to the Water Management Team by the Senior Director of Plant Operations and the Senior Director of Risk Management on 3/12/2025. 4. On 2/12/2025, the Director of Nursing began an audit of a minimum of five residents weekly x four weeks then monthly x two months of residents to ensure implementation of EBP and appropriate storage of nebulizers and nebulizer tubing. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately. The Administrator will monitor control measures in TELS monthly x three months beginning on 3/12/2025. The results of the monitoring will addressed in the QAPI meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65	F 880		

(CNA) #7 revealed revealed neither staff member donned a gown prior to beginning the care.

During an interview on 2/12/25 at 2:47 PM with CNA #7 she stated she had been in-serviced on EBP but was nervous and forgot to put the gown on. LPN#1 revealed that this was his second day back after not working at the facility for over a year, and when he previously worked at the facility, EBP were not used. He stated he had been instructed on this new process, but did not have a good understanding of what was required.

An interview with the Administrator on 2/12/25 at 2:55 PM, revealed EBP were required to reduce the spread of infection and should be used during care on a resident with a chronic wound. She confirmed the facility failed to use EBPs during wound care for this resident.

During an interview on 2/12/25 at 3:15 PM, the Director of Nursing (DON) revealed EBP were required to reduce the likelihood of the spread of infection to a vulnerable resident with a wound. She confirmed the facility failed to ensure EBP was used as required for a resident receiving pressure wound care, which increased the risk of an infection to the resident.

Record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 4/28/21 with medical diagnoses that included Protein Calorie Malnutrition, Polyneuropathy, History of Falling, and Chronic Pain.

Record review of Resident #11's Significant Change in Status "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) or 1/15/25 revealed a Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 66	F 880		

Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

Resident #82

During the initial tour on 2/10/25 at 11:05 AM, Resident #82's respiratory treatment nebulizer was noted on the floor next to the resident's bed. The tubing and mask were in a bag on top of the nebulizer. The resident stated he had lung issues and received treatments several times a day. He stated that he had asked staff about this being on the floor, but nothing was done differently.

An observation on 2/11/25 at 9:05 AM revealed the respiratory nebulizer on the floor by the resident's bed with tubing and mask lying on the floor next to nebulizer.

During an observation and interview on 2/11/25 at 1:30 PM, Resident #82 stated he had been at a doctor's appointment and received breathing treatment and pain medicine when he returned. Observation of nebulizer, tubing, and mask still on floor by bed.

During an observation in Resident #82's room and interview on 2/11/25 at 3:10 PM, the Director of Nursing (DON) verified that the resident's respiratory nebulizer, tubing, and mask were on the floor and was unacceptable. She stated this was a concern for infection control and the resident could "breathe bacteria into his lungs and become sick". She confirmed the nebulizer should be off the floor and the tubing and mask should be stored in a bag to ensure they remained clean. She confirmed the facility failed to ensure a resident's respiratory equipment was clean and stored properly to assist in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 67	F 880		

prevention of a respiratory infection.

Record review of Resident #82's "Order Summary Report" revealed an order dated 1/28/25 for "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligrams)/3 ml (milliliters) inhale orally three times a day for COPD (Chronic Obstructive Pulmonary Disease).

Record review of Resident #82's "Admission Record" revealed the facility most recently admitted the resident on 1/23/25 with medical diagnoses that included Wedge Compression Fracture of Fourth and Fifth Lumbar Vertebra, Malignant Neoplasm of Bronchus or Lung, Emphysema, and Chronic Obstructive Pulmonary Disease.

Record review of Resident #82's admission MDS with an ARD of 1/30/25 revealed a BIMS of 12 which indicated the resident had a moderate cognitive impairment.

Resident #157

During a medication administration observation for Resident #157 on 2/11/25 at 2:50 PM revealed, Registered Nurse (RN)#1 administered intravenous (IV) antibiotics via a Peripherally Inserted Central Catheter (PICC) to the right upper arm, with no observation of staff wearing a gown as part of EBP. A continued observation revealed no signage was visible to alert staff that the resident was on EBP.

In an interview with RN #1 on 2/11/25 at 2:55 PM, she confirmed she forgot to wear a gown for EBP and confirmed she knew that EBP should have been used because the resident has a PICC line.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 68	F 880		

She then revealed EBP is used for all residents with indwelling devices to add a layer of protection to reduce the risk of spreading infection. She also confirmed there was no signage on the door or in the residents' room alerting staff that EBP should be used.

In an interview with CNA #1 on 2/11/25 at 3:00 PM, she confirmed she was assigned to Resident # 157 and then revealed she was not aware that the resident was on EBP. She confirmed she had not been using the precautions. She stated she knew the resident had a PICC line, but there was no sign on the door, so she did not think he was on any precautions.

Record review of the "Order Summary Report" for Resident #157 revealed Cefazoline Fosamil 600 mg (milligrams) intravenously three times a day for septic discitis of the lumbar region until 3/10/25 with a start date of 2/5/25. ...

In an interview with the Director of Nursing (DON) on 2/13/25 8:13 AM, she confirmed that RN #1 should have used EBP to protect the residents from increased risk of transfer of bacteria. She also confirmed that an EBP sign should have been on the door to alert staff that the resident was on EBP.

Review of the "Admission Record" revealed the facility admitted Resident # 157 on 2/5/25 with a diagnosis that included Discitis of the Lumbar Region.

Record review of Resident #157s Section C of the Admission MDS with an ARD of 2/12/25 revealed the BIMS score was 15, indicating 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
	255119	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE