

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255119		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF AMORY				STREET ADDRESS, CITY, STATE, ZIP CODE 1215 EARL FRYE DRIVE , AMORY, Mississippi, 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	
F0000	INITIAL COMMENTS The State Agency (SA) conducted complaint investigations (CI# 2564871, CI# 2568272, CI# 2574939, CI# 495947, and Incident # 495948) at the facility from 8/20/25 through 8/21/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F 600 for Incident# 495948 related to abuse and F726 for CI# 2568272 related to Competent Staffing. The SA also investigated CI# 2564871, CI# 2574939, and CI# 495947 Quality of Care, Nursing Services , Environment, Activities of Daily Living, and Dining Services with no deficiencies cited. The census at the time of the survey was 116 with a bed capacity of 148 beds.		F0000				
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure that a resident was free from verbal		F0600				

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0600 SS = D	Continued from page 1 abuse when one (1) of seven (7) residents reviewed for abuse was subjected to verbal threats by a staff member. (Resident #1) Findings include: Review of the facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy," dated January 2019, revealed the purpose: "To prohibit and prevent abuse... in accordance with Federal and State laws." The policy defined verbal abuse as: "May be considered a form of mental abuse. Verbal abuse includes written or gestured communication, or sounds to residents within hearing distance, regardless of age, ability to comprehend, or disability." The policy further defined mental abuse as: "The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation..." Resident #1 Record review of a facility-reported investigation dated 6/8/25 at 7:00 PM related to allegations of threats revealed Resident #1 reported that Certified Nurse Assistant (CNA) #1 had taken the smokers out and shut the door in front of him. Resident #1 stated that when he reached the smoking area, he and CNA #1 exchanged words, and she told him she would slap him. He reported that when he replied she should not do that, she asked what he would do about it. He stated he told her he would call the police, and CNA #1 then stated she would put him in the morgue. Resident #1 also reported that he kept accusing her of slamming the door until she became angry and admitted she saw him before closing it. On 8/20/25 at 12:12 PM during an interview, Resident #1 recalled the incident in June. He stated CNA #1 knew he was behind her and slammed the door in his face. He reported he knocked on the door, but CNA #1 would not answer, and he had to ask someone else to open it. Resident #1 stated that when he confronted CNA #1 about shutting the door, she denied it, became upset, and they argued and cursed each other. Resident #1 confirmed that CNA #1 told him she would slap him, and when he threatened to call the police, she stated she would put him in the morgue. Review of the "Admission Record" revealed Resident #1 was admitted on 5/05/25 with a diagnosis of abnormalities of gait and mobility. Review of the Quarterly Minimum Data Set (MDS) for			F0600			

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F0600 SS = D	Continued from page 2 Resident #1 with an Assessment Reference Date (ARD) of 8/4/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident# 6 Record review of an interview with Resident #6 conducted as part of the facility's investigation revealed he heard CNA #1 threaten to slap Resident #1 and say she would put him in the morgue. He stated Resident #1 accused CNA #1 of slamming the door in his face. At first, CNA #1 denied it, but later admitted it. On 8/21/25 at 11:00 AM during an observation and interview, Resident #6 confirmed he heard CNA #1 threaten to slap Resident #1 and said she would put him in the morgue. He reported Resident #1 accused her of slamming the door in his face and that the two argued and cursed at each other. Record review of the "Admission Record" revealed Resident #6 was admitted on 5/02/25 with a diagnosis of centrilobular emphysema. Record review of the Quarterly MDS for Resident #6 with an ARD of 7/28/25, Section C, revealed a BIMS score of 15, indicating the resident was cognitively intact. Resident #7 Record review of an interview with Resident #7 conducted as part of the facility's investigation revealed, "I heard an argument between Resident #1 and CNA #1. I heard Resident #1 say CNA #1 let the door close in front of him before he could get to it. She got upset and they argued." Record review of the "Admission Record" revealed Resident #7 was admitted on 12/10/24 with a diagnosis of major depressive disorder. Record review of the Quarterly MDS for Resident #7 with an ARD of 6/3/25, Section C, revealed a BIMS score of 14, indicating the resident was cognitively intact. On 8/21/25 at 8:25 AM during an interview, the Administrator confirmed she substantiated the allegation of verbal abuse because CNA #1 had received previous training on abuse prevention and the investigation determined that another cognitively intact resident corroborated hearing CNA #1 curse at Resident #1. The Administrator stated CNA #1 denied		F0600				

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F0600 SS = D	Continued from page 3 saying she would put the resident in the morgue but admitted she cursed at him after he cursed at her. The Administrator confirmed CNA #1 acted in an unprofessional manner and that this conduct constituted verbal abuse which could lead to fear or psychosocial harm. On 8/21/25 at 8:35 AM during a phone interview, CNA #1 denied cursing Resident #1 or saying she would put him in the morgue. She confirmed she had received training on the definition of verbal abuse and de-escalation of potentially abusive situations. She stated she did not know why residents were reporting she had said this, but acknowledged she knew cursing at a resident is considered verbal abuse. She again denied closing the door on Resident #1 and stated he continued to accuse her of doing so.		F0600				
F0726 SS = F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to		F0726				

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F0726 SS = F	Continued from page 4 demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to ensure that newly hired licensed nurses and certified nurse assistants (CNAs) received skills competency checkoffs before providing resident care for three (3) of three (3) new hires reviewed. Findings include: Review of a form presented by the Administrator titled, "We Are Knowledgeable and Competent," revealed the expectation that new hire licensed practical charge nurses (LPN) complete a three-week skills checkoff process, to be signed by both the Administrator and the LPN charge nurse upon successful completion. On 8/21/25 at 8:48 AM during a phone interview conducted as part of the complaint investigation, Graduate Practical Nurse (GPN) # 1 stated she had graduated nursing school and began employment at the facility on 7/15/25. She reported that no staff had checked her off on any skills and she had not been provided with a skills checkoff form. She explained that she had not been assigned a specific preceptor and stated, "If I had questions, I just asked whoever was around." She further reported she felt overwhelmed with charting, admission paperwork, and incident reporting because the staff she shadowed during her first days of employment had not reviewed these processes with her. On 8/21/25 at 11:16 AM during an interview conducted as part of the complaint investigation, the Clinical Educator (CE) confirmed she was on vacation when GPN #1 began employment on 7/15/25. The CE stated that when she returned on 7/18/25, GPN #1 was on the medication cart by herself and each time she passed her in the hall, she was alone. She confirmed she had not performed any skills checkoffs with GPN #1 and was unsure if the former Director of Nursing (DON) had. She further stated, "She should not have been on the medication cart alone. She could have hurt someone." After reviewing the skills checkoff forms for Certified Nurse Assistant (CNA) #2 and CNA #3, the CE confirmed the forms were not signed by staff or trainers and she could not verify that the competencies had been completed. The CE explained it was very difficult to complete her educator responsibilities because she was frequently pulled to work the medication cart. She			F0726			

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F0726 SS = F	Continued from page 5 reported she had been in the educator role since March 2025 and had never obtained completed new hire skills checkoffs. She also stated she only learned of the "We Are Knowledgeable and Competent" LPN skills checkoff form one week prior during a meeting. Review of the "Z Slider Lift Skills Checklist" for CNA #2, dated 7/15/25, revealed the form was not signed as completed. The "Peri-Care Audit Tool" was not signed or dated by CNA #2, and the "Shaving, Nail, and Foot Care Audits" were checked as skills met but contained no staff or trainer name. Review of the "Z Slider Lift Skills Checklist" for CNA #3, dated 7/29/25, revealed the form was not signed as completed and no staff name was identified. The "Peri-Care Audit Tool" was not signed or dated by CNA #3, and the "Shaving, Nail, and Foot Care Audits" were checked as skills met but contained no staff or trainer name. On 8/21/25 at 12:00 PM during an interview, the Administrator stated the previous DON would have started GPN #1 on 7/15/25. She confirmed the facility was unable to locate any skills review forms for GPN #1. The Administrator acknowledged that all new hires should have skills checkoffs to ensure they are competent in their skills, and that failing to do so could result in residents not receiving care or receiving the wrong care.		F0726				