Mississippi State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**08/21/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **DIVERSICARE OF AMORY** | **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 |
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| M0000 | Initial Comments<br><br>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 the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for Incident # 495948 related to abuse. The SA also investigated CI# 2564871, CI# 2574939, CI# 2568272, and CI# 495947 for Quality of Care, Nursing Services, Environment, Activities of Daily Living, Dining Services, and Staffing with no deficiencies cited.<br><br>The census at the time of the survey was 116 with a bed capacity of 148 beds. | M0000 | | |
| M0500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, | M0500 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| M0500 | Continued from page 1<br>is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br><br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat | M0500 | | |

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| M0500 | Continued from page 2<br>to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br><br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); | M0500 | | |

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| M0500 | Continued from page 3<br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>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 abuse when one (1) of seven (7) residents reviewed for abuse was subjected to verbal threats by a staff member. (Resident #1)<br><br>Findings include:<br><br>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...”<br><br>Resident #1<br><br>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 | M0500 | | |

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| M0500 | Continued from page 4<br>before closing it.<br><br>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.<br><br>Review of the “Admission Record” revealed Resident #1 was admitted on 5/05/25 with a diagnosis of abnormalities of gait and mobility.<br><br>Review of the Quarterly Minimum Data Set (MDS) for 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.<br><br>Resident# 6<br><br>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.<br><br>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.<br><br>Record review of the “Admission Record” revealed Resident #6 was admitted on 5/02/25 with a diagnosis of centrilobular emphysema.<br><br>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.<br><br>Resident #7<br><br>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 | M0500 | | |

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| M0500 | Continued from page 5<br>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."<br><br>Record review of the "Admission Record" revealed Resident #7 was admitted on 12/10/24 with a diagnosis of major depressive disorder.<br><br>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.<br><br>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 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.<br><br>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. | M0500 | | |