STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PLACE NURSING CENTER	**1126 EARL FRYE BOULEVARD, SOUTH , 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 an annual re-certification survey at the facility from 12/15/25 through 12/18/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited, F558, F578, F605, F688, and F761. The census at the time of the survey was 49 and the facility is licensed for 60 beds.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure that a call light was within reach for one (1) of forty-nine residents observed. Resident #30. Findings Include: Review of the facility policy, "Call Light Policy" with revision date of 01/12/15, revealed "Procedure...8.When providing care to residents be sure to position the call light conveniently for the resident to use...." An observation on 12/16/25 at 11:00 AM and on 12/17/25 at 8:30 AM, revealed Resident #30 lying in her bed and the call light was not within reach. The call light cord was draped over her nightstand to the right of her bed with the red call button approximately two (2) feet from the head of her bed. During an observation and interview on 12/16/25 at 8:35 AM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #30's call light was draped over the nightstand to the right of her bed and it was not within her reach. CNA #1 revealed that Resident #30 was cognitive and could use the call light to voice her needs. She also revealed that the call light was	F0558		

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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F0558 SS = D	Continued from page 1 supposed to be within reach at all times so she could call for help when needed and stated, "If her call light is not in reach, it prevents her from getting the help she needs. An interview on 12/16/25 at 12:15 PM with Director of Nursing (DON), revealed that all call lights were supposed to be within reach of the residents. She also revealed that Resident #30 should have had her call light within her reach while in bed. DON revealed that failure to have a call light within reach could cause the resident to get up without assistance, and she could not call for help if she needed them. Record review of Resident #30's "Admission Record" revealed an admission date of 10/06/17 and that she had diagnoses that included Unspecified Dementia and Unspecified Anxiety Disorder. Record review of Resident #30's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/14/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 09 which indicated that she had moderate cognitive deficits.	F0558		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements	F0578		

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F0578 SS = D	Continued from page 2 of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's right for self-determination related to end-of-life care was respected as evidenced by resident not receiving the opportunity to sign her own code status directive for one (1) of 24 residents sampled. Resident #7 Findings include: Record review of facility policy titled, "Resident Rights", dated 10/24/22 revealed, "The resident has the right to be informed of, and participate in, his or her treatment, including: ... the right to request, refuse, and/or discontinue treatment ... The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice". Record review of facility policy titled, "Cardiopulmonary Resuscitation (CPR)", dated 11/30/15, revealed, "It is the policy of the facility to adhere to residents' rights to formulate advance directives". Record review of Resident #7's "Resident/Legal Representative Consent for Cardiopulmonary Resuscitation" revealed, "I understand that CPR constitutes an extraordinary measure and should not be done on me (the above-named resident)". This was signed by the resident's representative and the physician on 10/27/25. Record review of Resident #7's "Order Summary Report" revealed an order for "DNR (Do Not Resuscitate) dated 11/3/25. An interview with the Resident #7 on 12/15/25 at 2:58 PM, revealed she was capable of making her own decisions related to health care including her end-of-life care decisions and should have the opportunity to convey this decision in the documentation. She stated she would not want to be resuscitated if she arrested. During an interview on 12/17/25 at 3:20 PM, the Administrator acknowledged that each resident had the right to self-determination	F0578		

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F0578 SS = D	Continued from page 3 and the right to choose their end-of-life care. She acknowledged that Resident #7 was cognitive and fully oriented and should have been given the opportunity to receive information on end-of-life care and to sign her own code status form. She confirmed the facility failed to ensure the resident was given the opportunity to receive education and to consent to the end-of-life care she desired. Record review of Resident #7's "Admission Record" revealed she was admitted by the facility on 10/27/25, with diagnoses that included Malignant Neoplasm of Bladder. Record review of Resident #7's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/2/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F0578		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §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 . . . 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-. . .	F0605		

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F0605 SS = D	Continued from page 4 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. 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;	F0605		

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F0605 SS = D	Continued from page 5 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically 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 record review, staff interview, and facility policy review, the facility failed to initiate and implement a physician's order obtained during a Gradual Dose Reduction (GDR) attempt for 1 (one) of five (5) residents reviewed for unnecessary medications. Resident #39. Findings Include: Review of the facility policy "Gradual Dose Reduction of Psychotropic Drugs" with revision date of 05/03/18 revealed "Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." Record review of Resident #39's "Consultation Report" revealed a pharmacy recommendation to change Trazodone to 50 milligrams (mg) at bedtime as needed (PRN) for insomnia for 90 days. "Physician's Response: I accept the recommendation(s) above, please implement as written...." The "Consultation Report" was signed by the physician on 09/10/25. Record review of Resident #39's "Order Summary Report" revealed an order dated 10/11/25 for Trazodone HCL (Hydrochloride) 50mg by mouth in the evening related to insomnia, unspecified. Record review of Resident #39's "Medication	F0605		

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F0605 SS = D	Continued from page 6 Administration Record" revealed that he received Trazodone 50mg every evening. During an interview on 12/18/25 at 8:45 AM with Director of Nursing (DON), she pulled up Resident #39's orders on her computer and confirmed that his order for Trazodone 50mg every night was not changed to prn as recommended and ordered by the Physician. An interview on 12/18/25 at 9:05 AM with DON, revealed that when the pharmacist made the recommendations for a GDR, she was responsible for getting the recommendations to the physician and getting signatures. She revealed that once the physician signed and approved the recommendation, the DON was responsible for initiating the new orders in the computer. DON revealed that by not getting the order changed, Resident #39 continued to receive the Trazodone 50mg every night. She revealed that the goal was to get residents off as much medication and on the lowest dosage possible. She confirmed that they failed to follow through with the new order and this resulted in Resident #39 continuing his trazodone every night rather than only as needed. Record review of Resident #39's "Admission Record" revealed an admission date of 10/22/21 and that he had diagnoses that included Unspecified Dementia and Unspecified Insomnia. Record review of Resident #39's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/08/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 12 which indicated that he had moderate cognitive deficits.	F0605		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F0688		

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F0688 SS = D	Continued from page 7 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 provide services to maintain or prevent worsening of contractures for one of three residents reviewed with contractures. Resident #38. Findings Include: Review of the facility policy "Range of Motion" revealed "Policy: To safely move the resident's joints as full a range of motion as possible; To improve or maintain joint mobility and muscle strength; To prevent contractures; To increase strength and activity tolerance; To reduce pain; To prevent complications of mobility." An observation on 12/15/25 at 3:05 PM revealed Resident #38 sitting up in her wheelchair in her room. She had contractures to her left wrist and four fingers on the left hand. Her left wrist was bent downward and her second, third, fourth and fifth fingers were bent at the second joints, and she was unable to straighten them. An observation and interview on 12/16/25 at 12:04 PM with Resident #38 revealed her sitting in her wheelchair in her room. She had contractures to her left wrist and four fingers. Resident #38 revealed that she could not open her fingers all the way and could not move her left wrist. She revealed that her hand had been this way for a long time, it was getting worse and she had a lot of pain with it. An interview on 12/17/25 at 11:42 AM with Occupational Therapist (OT) revealed that Resident #38 had contractures when she came into the facility. OT also revealed that she had just completed her quarterly assessment in November, and that Resident #38 had not reached the point of needing therapy. She revealed that they usually treated contractures if they started causing skin breakdown or if the resident complained of pain. OT revealed that she didn't like to use splints because they often made the contractures worsen or caused swelling, but she could put a soft hand roll in Resident #38's hand to help. OT revealed that she had not measured Resident #38's contractures and agreed that by not assessing and measuring the contractures, she would not know if they worsened. She revealed that she would look at Resident #38 again, measure her contractures, and put something in place to help prevent a decline. An interview on 12/17/25 at 11:09 AM, DON revealed that Resident #38 had a contracture when she admitted to the facility. She revealed that she had a previous stroke and had therapy when she first came in. DON revealed that Resident #38 complained of pain to her left arm often and they had pain medication ordered for her. She also revealed that they encouraged the residents to participate in	F0688		

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F0688 SS = D	Continued from page 8 activities and with their Activities of Daily Living (ADL) to promote independence and better use of their joints. DON also confirmed that they did not have any range of motion exercises in place for her. DON confirmed that Resident #38's contractures were on her left wrist and four fingers and agreed that these contractures should have been identified and interventions should be in place to prevent worsening of the contractures. She also stated that by not providing services, her whole arm could become contracted. During an interview on 12/17/25 at 2:05 PM with Administrator (ADM), she agreed that Resident #38's contractures should have been identified and interventions should have been in place to prevent worsening. She revealed that by not providing services, her contractures could become worse and cause her more pain. She also revealed that without proper positioning and interventions, her fingers could become contracted more and cause skin breakdown. Record review of Resident #38's "OT Screening Form" completed on 11/19/25 and signed by OT, revealed that her Upper Extremity range of motion was within functional limit. Record review of Resident #38's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/21/25 under Section GG0115 Functional Limitation in Range of Motion revealed that she had upper and lower extremity impairment on one side. Record review of Resident #38's "Admission Record" revealed an admission date of 06/04/19 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side and Unspecified Pain. Record review of Resident #38's MDS with ARD of 11/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 10 which indicated that she had moderate cognitive deficits.	F0688		
F0761 SS = D	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	F0761		

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F0761 SS = D	Continued from page 9 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 on observation, resident and staff interviews, record review, and facility policy review, the facility failed to store medications in a secure manner for one (1) of forty-nine (49) residents observed during the initial tour. Resident #47 Findings Include: Review of the facility policy titled “Medication Storage” undated, revealed under, “Policy: Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments, and biologics must be stored securely and following the manufacturer’s Labeled recommendations, or per facility policy.” Also revealed under, “6. Medications will be stored on the medication cart, or in other designated area for extra supply of medications.” During an observation on 12/15/25 at 11:04 AM, Resident #47 was observed lying in bed and he was verbal but confused. A bottle of Antacids 750-milligram, approximately one-quarter full, was observed on the resident’s bedside dresser. The resident stated the medication belonged to him and that he took it when needed. An observation of Resident #47’s room on 12/16/25 at 11:34 AM revealed the bottle of Antacids remained located on the bedside dresser. An observation and interview with the Director of Nursing (DON) on 12/16/25 at 11:45 AM confirmed Resident #47 had the bottle of Antacids at the bedside. The DON stated the resident had intermittent confusion and should not have access to the medication. She further explained the resident could take too many tablets or another resident could enter the room and	F0761		

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F0761 SS = D	Continued from page 10 access the medication. Record review of the Admission Record revealed the facility admitted Resident #47 on 12/01/25 with medical diagnoses that included Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicating Resident #47 was moderately cognitively impaired.	F0761		