Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

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

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M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey at the facility from 4/13/26 through 4/16/26. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M500, M610, M620, M1210, and M1570.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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; 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; 3. is assured of adequate and appropriate medical care, 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	M0500		

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

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M0500	Continued from page 1 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; 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; 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; 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; 7. is free from mental and physical abuse; 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 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; 9. is assured security in storing personal possessions	M0500		

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M0500	Continued from page 2 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; 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; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 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); 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); 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); 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 16. is assured of exercising his civil and religious liberties including the right to independent personal	M0500		

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M0500	Continued from page 3 decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to dignity for one (1) of six (6) residents observed for dining, Resident #4. Findings include: A review of the facility's policy, "Residents' Rights in Nursing Centers," undated, revealed, "…Resident's rights are part of the federal Nursing Home Reform Law…The law requires nursing centers to 'promote and protect the rights of each resident' and places a strong emphasis on individual dignity…Specific Rights…The Right to Dignity, Respect, and Freedom, including the right to: Be treated with the fullest measure of consideration, respect, and dignity…" On 4/14/26 at 2:10 PM, during an observation, Registered Nurse (RN) #1 fed Resident #4 fortified pudding in the common television area with other residents present. RN #1 remained standing beside the resident while feeding and did not sit at eye level throughout the feeding. On 4/14/26 at 2:30 PM, during an interview, RN #1 acknowledged she did not sit while feeding Resident #4 and reported she forgot she was expected to sit while feeding residents. On 4/14/26 at 3:00 PM, during an interview, the Assistant Director of Nursing (ADON) confirmed staff were expected to sit while feeding residents to promote dignity during meals. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 1/13/26 with diagnoses including Dementia. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired.	M0500		
M0610	45.21.2 Activities of daily living	M0610		

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M0610	Continued from page 4 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) services resulting in unmet care needs for two (2) of 4 residents reviewed for ADL care, Resident #108 and Resident #102. Findings include: Review of the facility's policy titled "ADL's", dated August 2021, revealed, "…Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences…" Resident #108 On 4/13/26 at 11:40 AM and 4/14/26 at 9:00 AM, during observations and interviews, Resident #108 stated he preferred his fingernails to be kept short and he wanted them trimmed. His fingernails were noted to be long (approximately 3/4 inch from the tip of nailbed) and jagged with a brown substance under each nail. During an interview on 4/14/26 at 12:20 PM, the Director of Nursing (DON) acknowledged he observed Resident #108's fingernails and confirmed they were long, jagged, and dirty. He revealed it was his expectation that each resident received the activity of daily living (ADL) care which included nail care daily	M0610		

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M0610	Continued from page 5 and as needed to maintain nails at a length that was safe and preferred by the resident. He confirmed the facility failed to provide nail care for a dependent resident. Record review of the “Admission Record" revealed the facility originally admitted Resident #108 on 1/20/25 with the most recent admission date of 10/9/25. Diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date of 1/15/26, revealed Resident #108 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. RESIDENT #102 On 4/14/26 at 8:30 AM, during an observation and interview, Resident #102 was lying in bed and reported she was unable to get up without assistance and had requested a bedpan at approximately 8:00 AM. She reported staff had not returned and that she was told assistance would be provided after meal trays were passed. She indicated her breakfast tray had been delivered and removed, and she had still not received assistance. She reported feeling uncomfortable with a full bladder. On 4/14/26 at 8:34 AM, during an observation, Resident #102 activated the call light. At 8:42 AM, Certified Nursing Assistant (CNA) #1 entered the room and exited without providing toileting assistance. On 4/14/26 at 8:44 AM, during an interview, Resident #102 explained CNA #1 told her she would return with a bedpan. On 4/14/26 at 9:04 AM, during interview, CNA #1 was in the hallway and reported she was going to assist Resident #102. This occurred approximately one (1) hour and four (4) minutes after the initial request for toileting assistance. On 4/14/26 at 9:06 AM, during an interview, Registered Nurse (RN) #3 explained that when a resident requests assistance, including toileting during meal tray pass, CNAs are expected to stop and assist the resident while other staff continue tray distribution. RN #3 confirmed delayed toileting could result in the resident holding	M0610		

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M0610	Continued from page 6 urine, increasing the risk for urinary retention and urinary tract infection. On 4/14/26 at 9:15 AM, during an interview, the DON explained CNA #1 should have stopped and assisted Resident #102 at the time of request. He confirmed delaying toileting could result in incontinence, urinary retention, and increased infection risk, and emphasized the importance of meeting needs promptly, especially for a new resident. On 4/14/26 at 2:30 PM, during an interview, the Assistant Director of Nursing (ADON) confirmed awareness of the incident and reported CNA #1 should have delegated tray passing or notified the nurse if unable to assist immediately. The ADON explained the delay in toileting could lead to urinary retention, infection, or attempts to self-transfer, increasing fall risk. A record review of the “Admission Record” revealed the facility admitted Resident #102 on 1/27/22, with a most recent admission date of 3/31/26, and she had diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 4/7/26 revealed Resident #102 had a BIMS score of fourteen (14), which indicated she was cognitively intact. A review of Section GG revealed she required partial to moderate assistance for toilet transfers and substantial to maximal assistance with toileting hygiene.	M0610		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, and record review, the facility failed to provide services to prevent possible complications for one (1) of one (1) resident reviewed with an indwelling urinary catheter, Resident #11. Findings include:	M0620		

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M0620	Continued from page 7 A review of the facility's document, "Standards of Practice," on company letterhead revealed, "The expectation set forth…is that nurses comply with current standards of practice in terms of following the physician's orders on replacement of foley (type of indwelling catheter) catheters...." On 4/16/26 at 11:25 AM, during an observation and interview, Resident #11 reported he had a suprapubic catheter in place due to bladder cancer and had the catheter for a long time. He reported he could not remember the last time the catheter had been changed. On 4/16/26 at 11:30 AM, during an interview, Registered Nurse (RN) #3 explained that catheters were to be changed monthly unless otherwise specified in physician orders. She explained catheter change orders were located on the Treatment Administration Record (TAR) and the treatment nurse was responsible to complete them. She confirmed Resident #11 had an order for catheter changes every thirty (30) days. On 4/16/26 at 11:45 AM, during an interview, the Director of Nursing (DON) confirmed Resident #11 had an order for the suprapubic catheter to be changed every thirty (30) days on the 26th of each month. He reviewed the TAR and confirmed there was no documentation the catheter was changed in March 2026. He explained the catheter should be changed as ordered to help prevent infection. On 4/16/26 at 12:15 PM, during an interview, the DON confirmed the March 2026 catheter change was not completed and the care plan was not followed. A record review of the "Admission Record" revealed the facility admitted Resident #11 on 11/24/25 with diagnoses including Malignant Neoplasm of Bladder and Weakness. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/26 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. A record review of the "Order Summary Report" revealed Resident #11 had a Physician's Order, dated 1/26/26, to "Change out suprapubic catheter q (every) 30 days on 26th of the month…" A record review of the Treatment Administration Record (TAR) dated 3/1/26 - 3/31/26 revealed there was no documentation indicating Resident #11's suprapubic	M0620		

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M0620	Continued from page 8 catheter was changed on 3/26/26.	M0620		
M1210	45.40.7 Walls and Ceilings Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's right to a safe, clean, and homelike environment for one (1) of twenty-three (23) sampled residents, Resident #124. Findings include: A review of the facility's "Residents' Rights and Quality of Life Policy," dated 3/13/2020, revealed, "…It is the policy of (Proper Name of Facility) 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…Procedure…to receive services in a center environment that is safe, clean, and comfortable…" On 4/13/26 at 11/31 AM, during an observation, Resident #124's wall behind the headboard of her bed had a large area of missing paint measuring approximately four (4) feet by four (4) feet. In some areas, the top layer of sheetrock was visible. On 4/15/26 at 8:50 AM, during an observation and interview, the Maintenance Supervisor reported the damaged wall behind Resident #124's bed was an ongoing issue. He explained staff and family had been educated not to push the bed against the wall; however, the condition continued to occur. He reported staff completed daily rounds to identify maintenance concerns, but this issue had not been reported. He confirmed the condition did not provide a home-like environment and should have already been corrected. A record review of the "Work Orders" from 2/18/26 through 4/15/26 revealed there were no work orders to repair Resident #124's wall. On 4/16/26 at 11:27 AM, during an interview, the Administrator confirmed residents were expected to live	M1210		

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M1210	Continued from page 9 in a home-like environment and that a large area of missing paint on the wall did not meet that expectation and should have already been corrected. A record review of the “Admission Record” revealed the facility admitted Resident #124 on 2/14/24 with diagnoses including Moderate Protein-Calorie Malnutrition. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of ten (10), which indicated the resident’s cognition was moderately impaired.	M1210		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Widespread Based on observation, interview, record review, and facility policy review, the facility failed to implement infection control practices to prevent the spread of infection for four (4) of four (4) days of survey, which included not performing hand hygiene between residents during meal service (4/13/26 and	M1570		

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M1570	Continued from page 10 4/14/26), not maintaining aseptic technique during medication administration (4/15/26), and not ensuring biohazard waste was securely stored (4/16/26). Findings Include: Review of the facility's "Policies and Practices - Infection Control" dated 11/01/17 revealed, "The 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..." Meal Observation On 4/13/26 from 12:30 PM to 12:40 PM, during an observation of A-Wing lunch meal tray pass, staff did not perform hand hygiene between residents. Certified Nursing Assistant (CNA) #1 pushed the dietary cart down A-Wing and delivered trays and set up meals in Room #6, Room #12, Room #15, and Room #13 without sanitizing her hands between residents. CNA #2 removed a tray from the cart, entered Room #9, and exited without performing hand hygiene. She then removed another tray, entered Room #17, moved the television remote with her hand, and placed the tray on the bedside table. CNA #2 exited the room, retrieved another tray, and entered Room #13 to feed the resident. No hand hygiene was observed during the lunch meal tray pass. On 4/13/26 at 12:45 PM, during an interview, Certified Nursing Assistant (CNA) #1 confirmed she passed lunch meal trays without washing or sanitizing her hands between residents. She explained she was nervous and forgot to perform hand hygiene. She acknowledged she was expected to wash her hands prior to passing meal trays and sanitize her hands between residents. She confirmed failure to perform hand hygiene between residents could result in the spread of germs, contamination, and infection. On 4/13/26 at 12:55 PM, during an interview, CNA #2 explained staff passed out and set up trays for residents who could feed themselves first, then delivered trays to residents who required assistance with feeding. She reported staff washed their hands prior to handing trays out and confirmed she did not perform hand hygiene between residents while passing trays. She explained she was aware she was expected to perform hand hygiene between residents but forgot. She acknowledged failure to perform hand hygiene between residents could result in the spread of germs and possible infection.	M1570		

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M1570	Continued from page 11 On 4/14/26 from 11:45 AM to 11:55 AM, during an observation of A-Wing lunch meal tray pass, staff did not perform hand hygiene between residents. Certified Nursing Assistant (CNA) #3 entered Room #7 with a lunch tray and exited without using hand sanitizer. She then delivered trays to residents in Room #5 and Room #9 without performing hand hygiene between residents. During the same observation, CNA #4 removed a meal tray from the cart and delivered it to Room #6, exited the room, and returned to the cart to retrieve another tray. While in the hallway next to the cart, an unsampled resident propelled herself down the hall, spoke with CNA #4, and shook her hand. CNA #4 then retrieved another tray from the cart and delivered it to Room #14 without performing hand hygiene between resident rooms or after contact with the unsampled resident. An interview on 04/14/26 at 11:58 AM with CNA #3, revealed that she washed her hands when she left the kitchen to hand out trays and they were clean. She revealed that she wasn't aware of the need to wash hands or use hand sanitizer while passing out trays in between residents. She agreed that this could cause the spread of germs. An interview on 04/14/26 at 12:03 PM with CNA #4, revealed that she should have washed her hands after contact with the unsampled resident who came down the hall and touched her hand. She revealed that she was supposed to wash hands or use hand sanitizer between residents and by not washing her hands, she risked the spreading of germs which could cause possible infection. On 4/15/26 at 12:28 PM, during an interview, Registered Nurse (RN) #5, Infection Preventionist, explained staff were expected to wash their hands or use hand sanitizer between residents while passing meal trays. She explained staff should deliver a tray, set it up for the resident, and perform hand hygiene prior to entering another resident room. She reported meal trays were typically delivered first to residents who could feed themselves, followed by those who required assistance. She confirmed staff were aware of the expectation to perform hand hygiene between residents. She explained failure to perform hand hygiene between residents could result in cross contamination, spread of germs, and increased risk of residents becoming ill. Medication Administration On 4/15/26 at 8:45 AM, during an observation of medication administration, Registered Nurse (RN) #4	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

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

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M1570	Continued from page 12 administered Resident #23's morning medications through his Percutaneous Endoscopic Gastrostomy (PEG) tube. RN #4 pushed the medication cart into Resident #23's semi-private room. She washed her hands, applied a gown and gloves and assisted RN #5/Infection Preventionist to reposition the resident in the bed. Using the same gloves, RN #4, returned to the medication cart, retrieved the measuring tape, and then measured the PEG tube to ensure proper placement. RN #4 then walked back to the medication cart and prepared his medications without changing gloves. She pulled Resident #23's medications out of the medication cart and placed each tablet in the palm of her gloved hand prior to placing them into the individual medication packets. RN #4 then crushed the medications, changed her gloves and administered them by PEG tube. On 4/15/26 at 9:20 AM, during an interview, RN #4 confirmed she pushed the medication cart into Resident #23's room prior to administering medications. She confirmed she did not change gloves after resident contact and handled medications with the same gloves. She explained she should have changed gloves after resident contact and prior to medication preparation to prevent contamination. She acknowledged placing medications in the palm of her gloved hand could contaminate the medications and place the resident at risk for infection. She also confirmed the medication cart should have remained in the hallway during medication administration to prevent cross contamination. On 4/15/26 at 9:30 AM, during an interview, the Assistant Director of Nursing (ADON) confirmed medication carts should not be taken into resident rooms during medication pass due to risk of cross contamination. She also confirmed staff were expected to perform hand hygiene after resident contact and prior to handling medications. The ADON also confirmed that she was on A-Hall during the lunch meal tray pass the day before (4/14/26) and witnessed staff not performing hand hygiene between residents. On 4/15/26 at 10:25 AM, during an interview, RN #5/Infection Preventionist, confirmed medication carts should remain outside resident rooms during medication administration. She confirmed RN #4 failure to change gloves after resident contact and prior to medication administration could result in cross contamination and infection. A record review of the "Admission Record" revealed the facility admitted Resident #23 on 3/30/26 with diagnoses including Dysphagia.	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

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M1570	Continued from page 13 A record review of Resident #23's "Medication Administration Record (MAR)" revealed medications were administered via PEG tube on 4/15/26 during the AM, and documentation included verification of enteral tube placement by measurement prior to administration. Biohazard Waste Review of the facility's policy titled, "Regulated (Biohazard) Medical Waste," undated, revealed, "It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidelines and regulations…" On 4/16/26 at 12:20 PM, during an observation and interview, unsecured biohazard waste was observed in two red barrels located outside of the locked biohazard room. One barrel contained used gowns, gloves, and a sharps container with used needles. The lid was not locked and contents were accessible. The Maintenance Supervisor confirmed biohazardous waste should not be stored outside of the building at any time. On 4/16/26 at 12:30 PM, during an observation, the door to the outdoor biohazard room was shut and locked; however, the key was stored above the door frame and was accessible. On 4/16/26 at 12:40 PM, during an interview, the Administrator confirmed medical waste should be stored in a locked area and that storing used gowns, gloves, and needles in an unsecured outside barrel was not proper. She also confirmed the key to the biohazard room should be secured and not stored above the door frame.	M1570		