

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Diversicare of Amory		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Earl Frye Drive Amory, MS 38821	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>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.</p> <p>Findings include:</p> <p>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 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.</p> <p>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, [NAME], Storms, Heat index of 100+ and freezing temp of 32 degrees and below. **</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>In an interview on 2/12/25 at 11:15 AM, Central 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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 255119	If continuation sheet Page 1 of 34

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A record review of Resident A's MDS with an ARD of 1/16/25 revealed, under section C, a BIMS score of 15, which indicated the resident is cognitively intact.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>47874</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #8 on 7/25/12.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #14 on 11/27/12.</p> <p>Record review of Resident #14's MDS with an ARD of 11/11/24 revealed under, section C, a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #25 on 9/15/20.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #38 on 12/29/17.</p> <p>(continued on next page)</p>		

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	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.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46013</p> <p>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</p> <p>Findings Include:</p> <p>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 .</p> <p>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 .</p> <p>Resident #48</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident #60</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>Record review of Resident #60's Admission Record revealed the facility admitted the resident on 6/28/2023.</p> <p>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.</p> <p>C-7 Bathroom</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>Resident #99</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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 the right to a safe, comfortable, home-like environment and the facility failed to provide this for Resident #99.</p> <p>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.</p> <p>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.</p> <p>47157</p> <p>41878</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>47874</p> <p>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</p> <p>Findings Include:</p> <p>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.</p> <p>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 resident continued rocking forward in her wheelchair.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>An interview with the Nurse Practitioner (NP) on 2/12/25 at 10:08 AM revealed Resident #88 had 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.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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).</p> <p>Record review of the Admission Record revealed the facility admitted Resident #88 on 3/19/24 with a diagnosis that included Alzheimer's Disease.</p> <p>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.</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>47874</p> <p>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</p> <p>Findings Include:</p> <p>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 .</p> <p>Record review of Resident #63's Progress Notes dated 1/3/25 revealed the resident was transferred to the hospital following a fall.</p> <p>Record review of Resident 102's Progress Notes dated 1/27/25 revealed the resident was transferred to the hospital for altered mental status.</p> <p>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.</p> <p>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.</p> <p>Record review revealed the facility admitted Resident #63 on 7/25/23 with a medical diagnosis that included Alzheimer's Disease.</p> <p>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.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>41878</p> <p>Based on staff interviews, record review, and facility policy review, the facility failed to 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</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>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)</p> <p>Findings include:</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A review of the Baseline Care plan for Resident #253 dated 1/29/25 revealed no interventions related to personal hygiene.</p> <p>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.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.</p> <p>Record review of Resident #253,s Section C of the Admission Minimum Data Set (MDS) dated [DATE] 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.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>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</p> <p>Findings Include</p> <p>Record review of facility policy titled, Care Plans with effective date of October 2021, revealed, Care plans will be developed for all patients and 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.</p> <p>Resident #8</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>In an interview on 2/13/25 at 8:35 AM, the Director of Nurses (DON) confirmed she could 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>Resident #11</p> <p>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 ordered. Another care plan was for an infection related to wound infection with intervention administer antibiotics and treatment as ordered.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 resident had a moderate impairment cognitively.</p> <p>Resident #62</p> <p>Review of a care plan for Resident #62 titled, Nursing Kardex, revealed no interventions related to personal hygiene.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of Resident #62's Section C of the MDS dated [DATE] revealed the BIMS score was 13, indicating the resident was cognitively intact. Section: GG0130- I.) Personal hygiene-was coded setup or clean-up assistance.</p> <p>Resident #253</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.</p> <p>Record review of Resident #253's Section C of the MDS dated [DATE] 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).</p> <p>Resident #74</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #74's Care Plans revealed a care plan for Activities of Daily Living (ADL's) was not developed.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #74 on 11/30/23 with a medical diagnosis that included Cerebral Infarction.</p> <p>Resident #82</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>41878</p> <p>47157</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47874		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>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.</p> <p>Findings include:</p> <p>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) .</p> <p>Resident #62</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of Resident #62's Section C of the Annual Minimum Data Set (MDS) dated [DATE] 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.</p> <p>Resident #253</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.</p> <p>Record review of Resident #253's Section C of the Admission MDS dated [DATE] revealed the BIMS score was 9, indicating the resident was moderately cognitively impaired. Section: GG0130- I.) Personal hygiene-was coded partial/moderate assistance.</p> <p>Resident #74</p> <p>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.</p> <p>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.</p> <p>Record review revealed the facility admitted Resident #74 on 11/30/23 with a medical diagnosis that included Cerebral Infarction.</p> <p>47874</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>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</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>Resident #253</p> <p>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.</p> <p>An observation on 2/10/25 at 10:10 AM, revealed Resident #253 lying in the bed with regular socks on his feet.</p> <p>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.</p> <p>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.</p> <p>In an observation and interview with Licensed 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.</p> <p>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.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #253's Section C of the MDS dated [DATE] 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).</p> <p>Resident #303</p> <p>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.</p> <p>Record review of Resident #303's Order Summary Report revealed there were no orders for any skin concerns.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #303 on 1/30/25 with a diagnosis that included Acute Kidney Injury.</p> <p>47874</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>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.</p> <p>Findings include:</p> <p>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 .</p> <p>A record review of Resident #8's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses of Chronic Kidney Disease, Stage 5, and Dependence on Renal Dialysis.</p> <p>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.</p> <p>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.</p> <p>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 did not select dialysis on the quarterly MDS.</p> <p>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?</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 tried to complete the paperwork when she noticed the floor nurses were not doing it.</p> <p>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.</p> <p>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-Stage Renal Disease (ESRD).</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47157</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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 nurse to get a medication out of the medication room for him.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>47874</p> <p>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</p> <p>Findings Include:</p> <p>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 assessment in the facility for continuation of medication for each reinstatement of the order.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #69 on 9/30/21 with medical diagnoses that included Unspecified Dementia.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47157</p> <p>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) of three (3) narcotics refrigerator storage observed.</p> <p>Findings include:</p> <p>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 .</p> <p>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.</p> <p>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.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>47874</p> <p>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</p> <p>Findings Include:</p> <p>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.</p> <p>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 was not provided.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 coffee available throughout the day for the residents and stated the staff should get the things the residents request.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #13 on 11/02/23 with medical diagnoses that included Schizophrenia.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>47157</p> <p>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.</p> <p>Findings Include:</p> <p>This citation is cross-referenced to: F 584, F 656, F 677, F 684, F 761, and F 880</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>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, 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.</p> <p>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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41878</p> <p>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.</p> <p>Findings include:</p> <p>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 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 .</p> <p>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 .</p> <p>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, 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Diversicare of Amory		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Earl Frye Drive Amory, MS 38821	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Resident #11</p> <p>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.</p> <p>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 (CNA) #7 revealed revealed neither staff member donned a gown prior to beginning the care.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.</p> <p>Resident #82</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>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 prevention of a respiratory infection.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>Resident #157</p> <p>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.</p> <p>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. 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>47157</p>		