STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Amory	1215 Earl Frye Drive Amory, MS 38821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] without sanitizing her hands between residents. CNA #2 removed a tray from the cart, entered room [ROOM NUMBER], and exited without performing hand hygiene. She then removed another tray, entered room [ROOM NUMBER], 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 [ROOM NUMBER] 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. On 4/14/26 from 11:45 AM to 11:55 AM, during an observation of A-Wing lunch meal tray pass, staff (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	did not perform hand hygiene between residents. Certified Nursing Assistant (CNA) #3 entered room [ROOM NUMBER] with a lunch tray and exited without using hand sanitizer. She then delivered trays to residents in room [ROOM NUMBER] and room [ROOM NUMBER] without performing hand hygiene between residents. During the same observation, CNA #4 removed a meal tray from the cart and delivered it to room [ROOM NUMBER], 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 [ROOM NUMBER] 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on resident and staff interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions related to Activities of Daily Living (ADLs) (Resident #108 and #102) and wound care (Resident #3) for three (3) of 23 sampled residents. Findings Include: Review of the facility's policy Care Plans dated October 2021 revealed, Care plans will be developed and implemented for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines Resident #108 A record review of the Clinical Care Plan Detail revealed Resident #108 had a Focus of I have a Self Care Deficit. with Interventions/Tasks including Nail, hair, and oral care daily and as needed. On 4/13/26 at 11:40 AM and 4/14/26 at 9:00 AM, during observations and interviews, Resident #108 had long nails, approximately 3/4 inch from the top of the nailbed. There was also a brown substance noted underneath the nails. He stated he preferred his fingernails to be kept short and he wanted them trimmed. 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. Record review of the admission Record revealed the facility originally admitted Resident #108 on 1/20/26 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 1/15/25, revealed Resident #108 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact. RESIDENT #102 A record review of the Care Plan Report revealed Resident #102 had a Focus of I have a Self Care Deficit. The Goal was listed as My ADL needs will be met in a comfortable and caring manner. and the Interventions included toilet hygiene with substantial/maximum assistance support. On 4/14/26 at 8:30 AM, during an observation and interview, Resident #102 reported she had requested a bedpan at approximately 8:00 AM and staff had not returned to assist her. She reported feeling uncomfortable with a full bladder. On 4/14/26 at 9:04 AM, during interview, CNA #1 stated she was going to assist Resident #102, which was approximately one (1) hour and four (4) minutes after Resident #102 had requested toileting assistance. On 4/14/26 at 9:15 AM, during an interview, the DON stated that CNA #1 should have assisted (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #102 at the time of her request. 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. Resident #3 Record review of Resident #3's Care Plan Report revealed a focus area for I have non-pressure impaired skin integrity of the right posterior leg related to cellulitis wound and I have non-pressure impaired skin integrity related to wound to the right heel with goal of My affected area will heal without complications. The interventions listed included treatments as ordered. An interview with the Minimum Data Set (MDS) Registered Nurse on 4/15/26 at 10:53 AM revealed the purpose of the care plan was to provide an individualized plan of care with information on how to treat and provide care for each resident. She acknowledged that wound care was part of the care plan and the intervention to provide treatments as ordered was not followed. During an interview on 4/15/26 at 2:10 PM, the Director of Nursing stated his expectation was for each staff member to follow the care plan and to provide treatments as ordered. He confirmed the facility failed to follow the developed care plan for wound treatments as ordered for Resident #3. A record review of the Order Review revealed Resident #3 had Physician's Orders, dated 2/25/26, for Dakins solution to the right heel wound topically every day shift for wound infection and for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. A record review also revealed a Physician's Order, dated 3/5/26, to the right lateral lower leg to be cleaned with one-quarter (1/4) strength Dakins solution every day shift for cellulitis wound. A record review further revealed a Physician's Order, dated 2/25/26 and discontinued on 3/5/26, for treatment to the right posterior lower leg every Monday, Wednesday, and Friday. A record review of the Treatment Administration Record (TAR) for March 2026 revealed Resident #3 had a Physician's Order, dated 2/25/26, for Dakins solution to the right heel wound topically every day shift for wound infection. There was no documentation the treatment was performed on 3/4/26, 3/14/26, 3/15/26, 3/23/26, 3/25/26, 3/27/26, or 3/30/26 for a total of seven (7) missed treatments. A record review also revealed a Physician's Order, dated 2/25/26, for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. There was no documentation the treatment was performed on 3/4/26, 3/14/26, 3/15/26, 3/23/26, 3/25/26, 3/27/26, or 3/30/26 for a total of seven (7) missed treatments. A record review further revealed a Physician's Order, dated 3/5/26, to the right lateral lower leg to be cleaned with one-quarter (1/4) strength Dakins solution every day shift for cellulitis wound. There was no documentation the treatment was completed on 3/14/26, 3/15/26, 3/23/26, 3/25/26, 3/27/26, or 3/30/26 for a total of six (6) missed treatments. A record review also revealed a Physician's Order, dated 2/25/26 and discontinued on 3/5/26, for treatment to the right posterior lower leg every Monday, Wednesday, and Friday. There was no documentation indicating the treatment was performed on 3/4/26 for a total of one (1) missed treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Treatment Administration Record (TAR) for April 2026 revealed Resident #3 had a Physician's Order, dated 2/25/26, for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. There was no documentation the treatment was performed on 4/9/26 for a total of one (1) missed treatment. A record review of the admission Record revealed the facility admitted Resident #3 on 12/26/25 with diagnoses including Cellulitis of Right Lower Limb, Acute Osteomyelitis of Right Ankle and Foot, and Type 2 Diabetes Mellitus. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/26 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and facility policy review, the facility failed to ensure necessary care and services were provided to promote healing and prevent complications of a non-pressure wound, including failure to complete wound treatments as ordered and ensure accurate documentation of care for one (1) of two (2) residents reviewed for wounds, Resident #3. Findings include:A review of the facility's Skin Care Guideline, dated July 2018, revealed, 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/disruptions in skin integrity .A review of the facility's Standards of Practice, undated, revealed, Core Principles of Documentation Purpose: Facilitates interdisciplinary communications, provides a legal record of care.The ?Golden Rule': If it is not documented, it is considered not done.Best Practices Timeliness: Document as soon after the event as possible to avoid losing details.Legal Protections: Documentation acts as a key defense, ensuring care is aligned with established standards.On 4/13/26 at 12:15 PM, during an interview, Resident #3 reported he had diabetic wounds to his leg and foot and that dressings were scheduled to be changed daily. He reported the treatments had not been completed on several occasions. During the same observation, Resident #3 had a dressing and boot in place to the lower right leg.On 4/16/26 at 10:20 AM, during an interview, Licensed Practical Nurse (LPN) #2 reported she worked at the facility and at the wound clinic where Resident #3 received care. She explained she worked twelve (12)-hour shifts on weekends and occasionally worked evening shifts at the facility. She reported Resident #3 preferred for her to complete his wound treatments and she would provide the treatment even when not assigned to the resident. She acknowledged she did not document care on those occasions. She explained for multiple dates in March 2026 she could not recall with certainty whether treatments were completed due to lack of documentation. She reported she was not assigned to Resident #3 on 3/4/26 during the 5:30 PM to 11:00 PM shift and was unsure if treatment was completed. She reported on 3/14/26 she may have completed the treatment but would have reported it to the assigned nurse as she was not working on that hall. She reported on 3/15/26 she worked in the memory care unit and did not leave that area and did not complete the treatment. She reported she did not work on 3/25/26 or 3/27/26. She reported on 3/23/26 and 3/30/26 during the 7:00 PM to 11:00 PM shift she likely completed the treatment prior to the resident's wound clinic appointments. She acknowledged without documentation she could not confirm when care was provided. She confirmed accurate documentation was a standard of nursing practice and she had been in-serviced on completing and documenting treatments but failed to do so.On 4/16/26 at 11:15 AM, during an interview, the Director of Nursing (DON) confirmed if care was not documented it was not considered completed. He acknowledged some missed documentation could reflect documentation issues rather than omitted care; however, he confirmed there were multiple dates where ordered treatments were not completed. He explained failure to complete wound care as ordered could lead to worsening of the wounds. He confirmed staff were expected to complete ordered treatments and accurately document care and acknowledged the facility failed to follow these standards for Resident #3.A record review of the Order Review revealed Resident #3 had Physician's Orders, dated 2/25/26, for Dakins solution to the right heel wound topically every day shift for wound infection and for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. A record review also revealed a Physician's Order, dated 3/5/26, to the right lateral lower leg to be cleaned with one-quarter (1/4) strength Dakins solution every day shift for cellulitis wound. A record review further revealed a Physician's Order, dated 2/25/26 and discontinued on 3/5/26, for treatment to the right posterior lower leg every Monday, Wednesday, and Friday.A record review of the Treatment Administration Record (TAR) for March 2026 revealed Resident #3 had a Physician's Order, dated 2/25/26, for Dakins solution to the right heel wound topically every day shift for wound infection. There was no documentation the treatment was performed on 3/4/26, 3/14/26, 3/15/26, 3/23/26, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Amory	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/25/26, 3/27/26, or 3/30/26 for a total of seven (7) missed treatments. A record review also revealed a Physician's Order, dated 2/25/26, for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. There was no documentation the treatment was performed on 3/4/26, 3/14/26, 3/15/26, 3/23/26, 3/25/26, 3/27/26, or 3/30/26 for a total of seven (7) missed treatments. A record review further revealed a Physician's Order, dated 3/5/26, to the right lateral lower leg to be cleaned with one-quarter (1/4) strength Dakins solution every day shift for cellulitis wound. There was no documentation the treatment was completed on 3/14/26, 3/15/26, 3/23/26, 3/25/26, 3/27/26, or 3/30/26 for a total of six (6) missed treatments. A record review also revealed a Physician's Order, dated 2/25/26 and discontinued on 3/5/26, for treatment to the right posterior lower leg every Monday, Wednesday, and Friday. There was no documentation indicating the treatment was performed on 3/4/26 for a total of one (1) missed treatment.A record review of the Treatment Administration Record (TAR) for April 2026 revealed Resident #3 had a Physician's Order, dated 2/25/26, for the right heel to be packed moist-to-dry with one-quarter (1/4) strength Dakins solution daily and as needed. There was no documentation the treatment was performed on 4/9/26 for a total of one (1) missed treatment.A record review of the admission Record revealed the facility admitted Resident #3 on 12/26/25 with diagnoses including Cellulitis of Right Lower Limb, Acute Osteomyelitis of Right Ankle and Foot, and Type 2 Diabetes Mellitus.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/26 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 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: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.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 catheter was changed on 3/26/26.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were securely stored and administered in a manner that prevented them from being left unattended at the bedside for two (2) of twenty-three (23) sampled residents, Residents #35 and #44. Findings include: A review of the facility's policy, Medication Administration Guide, undated, revealed, Other best practice for medication administration includes: . observing that the resident/patient swallow medications administered. Do not leave medications at the bedside. A review of the facility's policy, Medication Storage, dated 4/2023, revealed, .Medications are accessible ONLY to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Resident #35 On 4/14/26 at 8:45 AM, during an observation and interview, Resident #35 was in her room and placed four (4) medication tablets from a medication cup into her hand and swallowed them. She reported the nurse left these medications, along with others she had already taken, at her bedside several minutes earlier. On 4/14/26 at 8:54 AM, during an interview, Licensed Practical Nurse (LPN) #1 acknowledged she left medications at Resident #35's bedside. She reported she had received in-service training on medication administration and was aware it was not safe to leave medications unattended. She explained she should have remained with the resident until the medications were taken. On 4/14/26 at 2:15 PM, during an interview, the Director of Nursing (DON) explained his expectation was for nurses to administer medications safely and follow medication administration guidelines. He confirmed this included observing the resident take the medication and not leaving medications unattended at the bedside. He confirmed the facility did not ensure the resident received medications safely by not remaining with the resident during administration. A record review of the Medication Administration Competency Audit - Oral Meds for LPN #1 revealed the action observes resident swallow medications was marked as met. A record review of the admission Record revealed the facility admitted Resident #35 on 11/27/12 with diagnoses including Primary Generalized Osteoarthritis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/26 revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. Resident #44 On 4/13/26 at 10:56 AM, during an observation and interview, Resident #44 had a prescription bottle of Nystatin powder with a prescription label affixed to the bottle at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/26 at 3:30 PM, during an observation and interview, the Interim Director of Nursing (DON) confirmed the bottle of Nystatin powder was on Resident #44's bedside table. Further review showed the prescription label belonged to the resident's roommate, Resident #92, and was not from the facility pharmacy. The Interim DON removed the medication from the room and informed Resident #44 he would consult the nurse practitioner regarding obtaining a prescription if needed. On 4/14/26 at 3:45 PM, during an interview, the Interim DON explained prescription medications should not be left at the bedside, especially medications from an unknown source. He explained the presence of medication not prescribed to the resident created a risk for medication errors or unintended use. A record review of the admission Record revealed the facility admitted Resident #44 on 7/28/25 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed Resident #44 had a BIMS score of fifteen (15), which indicated the resident was cognitively intact. A record review of the Order Summary Report with Active Orders As Of: 4/15/26 revealed Resident #44 did not have an active physician's order for Nystatin powder.