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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Place Nursing Center	1126 Earl Frye Boulevard, South 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review and facility policy review the facility failed to ensure that a call light was within reach for one (1) of forty-nine residents observed. Resident #30. Findings Include: Review of the facility policy, Call Light Policy with revision date of 01/12/15, revealed Procedure .8.When providing care to residents be sure to position the call light conveniently for the resident to use An observation on 12/16/25 at 11:00 AM and on 12/17/25 at 8:30 AM, revealed Resident #30 lying in her bed and the call light was not within reach. The call light cord was draped over her nightstand to the right of her bed with the red call button approximately two (2) feet from the head of her bed. During an observation and interview on 12/16/25 at 8:35 AM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #30's call light was draped over the nightstand to the right of her bed and it was not within her reach. CNA #1 revealed that Resident #30 was cognitive and could use the call light to voice her needs. She also revealed that the call light was supposed to be within reach at all times so she could call for help when needed and stated, If her call light is not in reach, it prevents her from getting the help she needs. An interview on 12/16/25 at 12:15 PM with Director of Nursing (DON), revealed that all call lights were supposed to be within reach of the residents. She also revealed that Resident #30 should have had her call light within her reach while in bed. DON revealed that failure to have a call light within reach could cause the resident to get up without assistance, and she could not call for help if she needed them. Record review of Resident #30's admission Record revealed an admission date of 10/06/17 and that she had diagnoses that included Unspecified Dementia and Unspecified Anxiety Disorder. Record review of Resident #30's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/14/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 09 which indicated that she had moderate cognitive deficits.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's right for self-determination related to end-of-life care was respected as evidenced by resident not receiving the opportunity to sign her own code status directive for one (1) of 24 residents sampled. Resident #7Findings include: Record review of facility policy titled, Resident Rights, dated [DATE] revealed, The resident has the right to be informed of, and participate in, his or her treatment, including: . the right to request, refuse, and/or discontinue treatment . The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. Record review of facility policy titled, Cardiopulmonary Resuscitation (CPR), dated [DATE], revealed, It is the policy of the facility to adhere to residents' rights to formulate advance directives. Record review of Resident #7's Resident/Legal Representative Consent for Cardiopulmonary Resuscitation revealed, I understand that CPR constitutes an extraordinary measure and should not be done on me (the above-named resident). This was signed by the resident's representative and the physician on [DATE]. Record review of Resident #7's Order Summary Report revealed an order for DNR (Do Not Resuscitate) dated [DATE]. An interview with the Resident #7 on [DATE] at 2:58 PM, revealed she was capable of making her own decisions related to health care including her end-of-life care decisions and should have the opportunity to convey this decision in the documentation. She stated she would not want to be resuscitated if she arrested. During an interview on [DATE] at 3:20 PM, the Administrator acknowledged that each resident had the right to self-determination and the right to choose their end-of-life care. She acknowledged that Resident #7 was cognitive and fully oriented and should have been given the opportunity to receive information on end-of-life care and to sign her own code status form. She confirmed the facility failed to ensure the resident was given the opportunity to receive education and to consent to the end-of-life care she desired. Record review of Resident #7's admission Record revealed she was admitted by the facility on [DATE], with diagnoses that included Malignant Neoplasm of Bladder. Record review of Resident #7's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, staff interview, and facility policy review, the facility failed to initiate and implement a physician's order obtained during a Gradual Dose Reduction (GDR) attempt for 1 (one) of five (5) residents reviewed for unnecessary medications. Resident #39.Findings Include: Review of the facility policy Gradual Dose Reduction of Psychotropic Drugs with revision date of 05/03/18 revealed Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Record review of Resident #39's Consultation Report revealed a pharmacy recommendation to change Trazodone to 50 milligrams (mg) at bedtime as needed (PRN) for insomnia for 90 days. Physician's Response: I accept the recommendation(s) above, please implement as written The Consultation Report was signed by the physician on 09/10/25. Record review of Resident #39's Order Summary Report revealed an order dated 10/11/25 for Trazodone HCL (Hydrochloride) 50mg by mouth in the evening related to insomnia, unspecified. Record review of Resident #39's Medication Administration Record revealed that he received Trazodone 50mg every evening. During an interview on 12/18/25 at 8:45 AM with Director of Nursing (DON), she pulled up Resident #39's orders on her computer and confirmed that his order for Trazodone 50mg every night was not changed to prn as recommended and ordered by the Physician. An interview on 12/18/25 at 9:05 AM with DON, revealed that when the pharmacist made the recommendations for a GDR, she was responsible for getting the recommendations to the physician and getting signatures. She revealed that once the physician signed and approved the recommendation, the DON was responsible for initiating the new orders in the computer. DON revealed that by not getting the order changed, Resident #39 continued to receive the Trazodone 50mg every night. She revealed that the goal was to get residents off as much medication and on the lowest dosage possible. She confirmed that they failed to follow through with the new order and this resulted in Resident #39 continuing his trazodone every night rather than only as needed. Record review of Resident #39's admission Record revealed an admission date of 10/22/21 and that he had diagnoses that included Unspecified Dementia and Unspecified Insomnia. Record review of Resident #39's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/08/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 12 which indicated that he had moderate cognitive deficits.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, staff and resident interviews, record review and facility policy review the facility failed to provide services to maintain or prevent worsening of contractures for one of three residents reviewed with contractures. Resident #38.Findings Include: Review of the facility policy Range of Motion revealed Policy: To safely move the resident's joints as full a range of motion as possible; To improve or maintain joint mobility and muscle strength; To prevent contractures; To increase strength and activity tolerance; To reduce pain; To prevent complications of mobility. An observation on 12/15/25 at 3:05 PM revealed Resident #38 sitting up in her wheelchair in her room. She had contractures to her left wrist and four fingers on the left hand. Her left wrist was bent downward and her second, third, fourth and fifth fingers were bent at the second joints, and she was unable to straighten them. An observation and interview on 12/16/25 at 12:04 PM with Resident #38 revealed her sitting in her wheelchair in her room. She had contractures to her left wrist and four fingers. Resident #38 revealed that she could not open her fingers all the way and could not move her left wrist. She revealed that her hand had been this way for a long time, it was getting worse and she had a lot of pain with it. An interview on 12/17/25 at 11:42 AM with Occupational Therapist (OT) revealed that Resident #38 had contractures when she came into the facility. OT also revealed that she had just completed her quarterly assessment in November, and that Resident #38 had not reached the point of needing therapy. She revealed that they usually treated contractures if they started causing skin breakdown or if the resident complained of pain. OT revealed that she didn't like to use splints because they often made the contractures worsen or caused swelling, but she could put a soft hand roll in Resident #38's hand to help. OT revealed that she had not measured Resident #38's contractures and agreed that by not assessing and measuring the contractures, she would not know if they worsened. She revealed that she would look at Resident #38 again, measure her contractures, and put something in place to help prevent a decline. An interview on 12/17/25 at 11:09 AM, DON revealed that Resident #38 had a contracture when she admitted to the facility. She revealed that she had a previous stroke and had therapy when she first came in. DON revealed that Resident #38 complained of pain to her left arm often and they had pain medication ordered for her. She also revealed that they encouraged the residents to participate in activities and with their Activities of Daily Living (ADL) to promote independence and better use of their joints. DON also confirmed that they did not have any range of motion exercises in place for her. DON confirmed that Resident #38's contractures were on her left wrist and four fingers and agreed that these contractures should have been identified and interventions should be in place to prevent worsening of the contractures. She also stated that by not providing services, her whole arm could become contracted. During an interview on 12/17/25 at 2:05 PM with Administrator (ADM), she agreed that Resident #38's contractures should have been identified and interventions should have been in place to prevent worsening. She revealed that by not providing services, her contractures could become worse and cause her more pain. She also revealed that without proper positioning and interventions, her fingers could become contracted more and cause skin breakdown. Record review of Resident #38's OT Screening Form completed on 11/19/25 and signed by OT, revealed that her Upper Extremity range of motion was within functional limit. Record review of Resident #38's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/21/25 under Section GG0115 Functional Limitation in Range of Motion revealed that she had upper and lower extremity impairment on one side. Record review of Resident #38's admission Record revealed an admission date of 06/04/19 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side and Unspecified Pain. Record review of Resident #38's MDS with ARD of 11/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 10 which indicated that she had moderate cognitive deficits.

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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, resident and staff interviews, record review, and facility policy review, the facility failed to store medications in a secure manner for one (1) of forty-nine (49) residents observed during the initial tour. Resident #47 Findings Include:Review of the facility policy titled Medication Storage undated, revealed under, Policy: Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments, and biologics must be stored securely and following the manufacturer's Labeled recommendations, or per facility policy. Also revealed under, 6. Medications will be stored on the medication cart, or in other designated area for extra supply of medications.During an observation on 12/15/25 at 11:04 AM, Resident #47 was observed lying in bed and he was verbal but confused. A bottle of Antacids 750-milligram, approximately one-quarter full, was observed on the resident's bedside dresser. The resident stated the medication belonged to him and that he took it when needed.An observation of Resident #47's room on 12/16/25 at 11:34 AM revealed the bottle of Antacids remained located on the bedside dresser.An observation and interview with the Director of Nursing (DON) on 12/16/25 at 11:45 AM confirmed Resident #47 had the bottle of Antacids at the bedside. The DON stated the resident had intermittent confusion and should not have access to the medication. She further explained the resident could take too many tablets or another resident could enter the room and access the medication.Record review of the admission Record revealed the facility admitted Resident #47 on 12/01/25 with medical diagnoses that included Unspecified Dementia.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicating Resident #47 was moderately cognitively impaired.