Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	**156 E WALNUT AVE , EUPORA, Mississippi, 39744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS# 500070, CI MS# 2567061, CI MS# 2600535, CI MS# 2580120 and Facility Reported Incident (FRI)# 2577877 at the facility from 8/27/25 through 8/28/25. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for CI MS# 2580120 and FRI # 2577877 for resident rights. There were no deficiencies cited for CI MS# 500070, CI MS# 2567061, CI MS# 2600535, related to pressure ulcers, assessing/monitoring, call lights, environment, quality of care, and food services. The census at the time of the survey was 111 with a bed capacity of 119 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M0500		

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

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M0500	Continued from page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or	M0500		

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M0500	Continued from page 2 unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M0500		

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M0500	Continued from page 3 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to ensure residents were free from abuse when a Licensed Practical Nurse (LPN) used profanity toward a resident diagnosed with Alzheimer's disease and was alleged to have applied physical force during care, placing the resident at risk for humiliation, intimidation, and harm. This failure was identified for one (1) of six (6) residents reviewed for abuse (Resident #1). Findings include: Review of the facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy," dated January 2019, revealed, "Purpose: To prohibit and prevent abuse… · Physical Abuse – includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Corporal punishment is considered physical abuse. · Verbal Abuse – may be considered a form of mental abuse and includes written, gestured, or spoken communication, or sounds made to residents within hearing distance, regardless of age, ability to comprehend, or disability. · Mental Abuse – is the use of verbal or nonverbal conduct which causes, or has the potential to cause, humiliation, intimidation, fear, shame, agitation, or degradation...." Record review of a facility-reported incident revealed that on 7/29/25, Certified Nursing Assistants (CNAs) #1 and CNA #2 reported allegations of abuse by LPN #1	M0500		

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M0500	Continued from page 4 toward Resident #1. Record review of the “Admission Record” revealed Resident #1 was admitted on 7/21/25 with diagnoses of Alzheimer’s disease and dementia with agitation. Record review of the Admission Minimum Data Set (MDS) dated 7/28/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired. During an interview with the Administrator and the DON on 8/28/25 at 9:31 AM, they confirmed that CNA #1 and CNA #2 told them they were at the nurse’s station during the incident, placing them away from the immediate area. They stated LPN #2 reported hearing LPN #1 use profanity but not directed at the resident. They confirmed that, following their investigation, the facility substantiated the use of profanity but did not substantiate the allegation of abuse or improper physical force. During an interview on 8/27/25 at 2:30 PM, CNA #1 stated that on 7/28/25 sometime after 7:00 PM, Resident #1 was acting out, cursing, hitting, biting at staff, and had laid down in the hallway. She stated that staff were attempting to calm and redirect the resident’s behaviors when LPN #1 was holding the resident's legs and the resident kicked LPN #1 in the stomach, LPN #1 then became angry and called the resident a “stupid b****” and shoved her legs back into her chest. She stated it appeared as if LPN #1 “just snapped” when the resident kicked her. She confirmed she was in the hallway with LPN #1, LPN #2, CNA #2, and CNA #3 when the incident occurred and denied ever stating she was at the nurse’s station. She stated that aside from sending a text message to the Administrator to report the incident, no one questioned her further. Review of a written statement provided by the Administrator and attributed to the interview that CNA #1 gave, revealed the following allegation: “LPN #1 folded that lady’s leg up to her chest then she kicked LPN #1 and LPN #1 called her a b**** and shoved her leg/knee back in her chest.” During a phone interview with CNA #2 on 8/27/25 at 2:40 PM, she stated Resident #1 was confused, fighting, hitting, kicking, and biting at staff. She stated staff were blocking the resident from hitting and kicking while trying to calm her down. She stated the resident managed to kick LPN #1 in the stomach, and LPN #1 called the resident a “stupid b****” and pushed the resident’s leg back toward her head. She confirmed she	M0500		

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M0500	Continued from page 5 was present in the hallway during the incident and denied telling the Administrator or Director of Nursing (DON) that she had been at the nurse's station. She confirmed that she had sent the Administrator a text to let her know about the incident. Record review of a written statement provided by the Administrator and attributed to CNA #2 revealed: "I love LPN #1 to death, but she went entirely too far when Resident #1 kicked her. Then she called her a "stupid b****." During a phone interview with LPN #2 on 8/27/25 at 3:30 PM, she stated she worked on 7/28/25 and recalled Resident #1 being confused, resisting care, and fighting, kicking, and biting staff. She stated that staff attempted to block the resident's arms and legs to prevent injury. She denied seeing the incident but confirmed she heard LPN #1 use profanity in an attempt to calm the resident. She stated that while she did not view it as cursing at the resident, she acknowledged that profanity and blocking movements could have made the resident feel threatened. Record review of a written statement provided by the Administrator and attributed to LPN #2 revealed: "On 7/28/25 approximately 1900, LPN #1 did use profanity to get patient to stop kicking." Record review of an interview summary conducted by the Administrator and the DON revealed LPN #1 stated she heard a commotion, Resident #1 was on the floor in the hallway, kicking and biting. She stated she did not recall using any profanity during the situation. She stated she did push the resident's leg while trying to block the kick as the resident was trying to kick her and the CNAs. Record review of a "Progressive Discipline Form" for LPN #1 dated 8/5/25 revealed: "On 7/28/25 it was reported that profane language was used with a resident. It was also alleged that physical force was used with the resident. Upon completion of the investigation, it was determined that profane language was used; however, no improper force was substantiated." Record review of an in-service titled "Abuse and Neglect," dated 7/1/25, revealed LPN #1, LPN #2, CNA #1, and CNA #2 attended the training and signed the attendance sheet.	M0500		