

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255117		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/28/2025	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF EUPORA				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0000	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 participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F 600 and F 609 for CI MS# 2580120 and FRI# 2577877) for abuse and reporting abuse. There were no deficiencies cited for CI MS# 500070, CI MS# 2567061, and 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.		F0000				
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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		F0600				

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 reverse for further 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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F0600 SS = D	Continued from page 1 Alzheimer's disease and was observed to have applied physical force during an incident, where the resident was laying flat on her back on the floor and the LPN forcefully pushed the resident's legs into her chest and used profanity toward the resident. This placed the resident at risk for humiliation, intimidation, and harm. This was identified for one (1) of six (6) residents reviewed for abuse (Resident #1). Findings include: Cross-reference F609 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 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		F0600				

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F0600 SS = D	Continued from page 2 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 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		F0600				

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F0600 SS = D	Continued from page 3 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.		F0600				
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term		F0609				

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F0609 SS = D	Continued from page 4 care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure that all allegations of abuse were immediately reported to the State Agency, failed to report allegations involving a licensed nurse to the appropriate licensing board, and failed to ensure staff recognized and reported abuse. This deficient practice was identified for one (1) of three (3) residents reviewed for abuse allegations. (Resident #1) Findings include: Cross-reference F 600 Review of the facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy," dated January 2019, revealed: "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, will be reported immediately to the Administrator, State Agency, and other officials in accordance with State law. Allegations involving licensed staff will be reported to the appropriate licensing authority." Record review of a facility-reported incident dated 7/29/25 revealed allegations of abuse were made against Licensed Practical Nurse (LPN) #1 involving Resident #1. The incident was reported to the State Agency; however, the facility did not notify to the Board of Nursing as required for allegations involving licensed staff. During an interview with Certified Nursing Assistant (CNA) #1 on 8/27/25 at 2:30 PM, she stated she witnessed the incident on 7/28/25 when LPN #1 used profanity and applied force to Resident #1. She stated she did not report the allegation until the next day because she assumed another nurse would have reported it. During a phone interview with CNA #2 on 8/27/25 at 2:40		F0609				

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F0609 SS = D	Continued from page 5 PM, she confirmed she also witnessed the incident but delayed reporting until the following day because she assumed another nurse had already reported it. During a phone interview with LPN #2 on 8/27/25 at 3:30 PM, she stated she heard LPN #1 use profanity toward Resident #1 but did not consider it abuse and therefore did not report the allegation either. LPN #2 confirmed that it is never okay to use profanity towards a resident and that she was the supervisor over the CNAs and she should have reported the incident right away. During an interview with the Administrator and the Director of Nursing (DON) on 8/28/25 at 9:31 AM, they confirmed that staff failed to immediately report allegations of abuse that occurred on 7/28/25 related to LPN #1 and Resident #1. They also confirmed the allegation was not reported to the Board of Nursing because the facility did not substantiate the abuse, although they had statements of abuse from both CNAs. Record review of an in-service titled "Abuse and Neglect," dated 7/1/25, revealed LPNs #1 and #2 and CNAs #1 and #2 attended the training and signed the attendance sheet. In-service material: If any allegations of abuse that is reported to any team member, it is to be reported immediately. ...Remember to always report any suspicion of abuse and neglect immediately. ... Different types of abuse. ...when in doubt report it. ...	F0609					