STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Eupora	156 E Walnut Ave Eupora, MS 39744

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 F609Review 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 [DATE] with diagnoses of Alzheimer's disease and dementia with agitation.Record review of the admission Minimum Data Set (MDS) dated [DATE] 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 (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 600Review 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 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.