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	02/26/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, resident representative, and staff interviews, along with facility policy review, the facility failed to ensure residents were treated with dignity and respect by providing timely toileting assistance and honoring residents right for two (2) of 25 sampled residents reviewed. Resident #5 and Resident #18. Findings Include: Review of the facility policy titled Resident Rights & Quality of Life Policy, with an effective date of March 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. Resident #5 During an interview on 2/23/2026 at 11:41 AM, Resident #5 revealed that at approximately 11:00 PM, she activated her call light requesting assistance to the bathroom, at which time Certified Nurse Aide (CNA) #1 responded and stated, Didn't someone come in here earlier and take you to the bathroom? The resident stated she informed CNA #1 that she had been asleep and needed to go at that time, and CNA #1 then assisted her. Resident #5 further revealed that at approximately 3:00 AM she again required toileting assistance. Although CNA #1 assisted her to the bathroom, she was left sitting on the toilet for approximately thirty (30) minutes without supervision. The resident stated she waited for CNA #1 to return and, when she did not, she activated the bathroom call light; upon returning, CNA #1 stated, I told you I was coming back. I had to make my rounds. Resident #5 stated she informed CNA #1 that she could not sit on the toilet for that length of time and should not have to remain there for an extended period and further reported that she notified the night nurse of the concern and was told the issue would be reported to Registered Nurse (RN) #2 in the morning. During an interview on 2/25/2026 at 2:10 PM, Registered Nurse (RN) #2 revealed she was not made aware of any complaints or concerns with Resident #5 on Monday morning. In an interview on 2/25/2026 at 2:15 PM, Licensed Practical Nurse (LPN) #1 revealed there have been prior issues involving CNA #1 that she was not professional and not friendly with the residents, which were reported to the Director of Nursing (DON). On 02/25/2026 at 3:05 PM, during an interview, the DON stated the CNA #1 can be kind of gruff in her tone, and further revealed that all residents are to be treated with the utmost respect and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2026 at 9:05 AM, during a follow-up interview, the DON revealed CNA #1 has received multiple write-ups in the past. She stated she has provided verbal coaching to CNA #1 related to activities of daily living (ADL) care and service standards. The DON further revealed that CNA #1 previously received a write-up for leaving a resident on the toilet longer than appropriate. The DON revealed it is our expectation that residents receive timely toileting and confirmed that not doing so could place residents in discomfort and loss of personal dignity. Record review of the admission Record revealed Resident #5 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/5/26 revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #5 was cognitively intact. Resident #18 An interview with a family member on 2/24/26 at 2:10 PM revealed she had entered the facility around 1:05 PM that day to visit Resident #18, whose call light was sounding because she was wet and needed to be changed. The family member revealed that the resident was left with 3 soiled towels on top of her chest from the lunch meal which was covered in spaghetti. The family member revealed that the call light had been going off for some time and the day shift CNA #5 entered the room to remove the soiled towels and stated to Resident #18, You're just showing out because your sister is here. A telephone interview with CNA #5 on 2/26/26 at 10:46 AM revealed she did not recall making the statement to Resident #18. She confirmed dirty towels were left on the resident's chest area from lunch. CNA #5 did confirm that the family was upset and that she just left the room to allow time for it to deescalate. An interview with the DON on 2/26/26 at 3:30 PM confirmed her expectations were that all residents have the right to be treated with dignity and respect. Record review of the admission Record revealed Resident #18 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Palsy. Record review of the MDS with an ARD of 1/26/26 revealed under Section C a BIMS summary score of 13, indicating Resident #18 was cognitively intact. Section H revealed the resident was always incontinent of bladder and frequently incontinent of bowel. Additionally, Section GG revealed Resident #18 was dependent on staff for toileting and personal hygiene.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review, and facility policy review, the facility failed to ensure licensed nursing staff followed professional standards of practice related to accurate and individualized documentation of as needed (PRN) pain medication administration for 13 of 25 residents reviewed on the B-hall medication cart. This deficient practice resulted in repetitive clustered documentation of PRN narcotic pain medications at identical times for multiple residents, which did not reflect individualized assessment or real-time documentation of care provided. Resident #9, #12, #22, #27, #38, #43, #44, #47, #61, #65, #68, #95 and unsampled Resident D. Findings Include:Record review of the facility policy tilted Medication Administration with a review date of 4/23 revealed under, Policy; Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so.Record review of the facility policy titled Purpose of the Patient Record undated, revealed under, Guidelines: To ensure Patient Clinical Health information records are maintained in accordance with professional practice standards. Also revealed under, Process: Clinical records are maintained to provide complete and accurate patient information for continuity of care.Record review of the facility Clinical Care System Guidelines titled Pain Management Guidelines revealed under, Purpose: To provide guidelines for consistent evaluation, management and documentation of pain in order to provide maximum comfort and enhanced quality of life.During initial tour on 2/23/26 at 11:14 AM, a resident who wished to remain anonymous revealed she was prescribed Norco 10 milligrams every 6 hours as needed for pain. The resident stated she had concerns regarding pain medication administration. She reported the nurse brought medications in a cup and attempted to administer them without allowing her to visually verify the medication. The resident stated she questioned whether her pain medication was included and was told yes; however, she did not receive relief afterward. She further stated that on one occasion she looked into the medication cup and did not see her Norco. When questioned, the nurse indicated the pill was broken. The resident stated the pill did not resemble her usual Norco, which she described as a white, oblong, football-shaped pill. The resident stated she initially did not report concerns because she liked the nurse and did not want to cause conflict. She later requested her physician schedule pain medication routinely due to continued concerns. She stated Norco typically controlled her pain but had not since residing in the facility.An observation and interview on 2/23/26 at 3:10 PM revealed Resident #9 lying in bed. He denied pain, and stated he did not take pain medication, and reported refusing pain medication when offered by nursing staff.Record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed under Section J that, in the last five days, the resident experienced frequent pain affecting sleep and limiting day-to-day activities.Record review of Resident #9's January and February 2026 Medication Administration Record (MAR) revealed Norco 5/325 mg (milligrams) ordered every six hours as needed for moderate pain. Documentation reflected administration by Licensed Practical Nurse (LPN) #3 at consistent times of 7:01 AM, 12:31 PM, and evening times ranging between 6:31 - 6:49 PM (1831-1849). Record review of the Controlled Substance Inventory Record dated 12/04/25 for Resident #9 revealed a narcotic sign out sheet for Norco 5/325 quantity 60 pills with sign out times by LPN #3 of 0700, 1230 and 1830 for 58 of the 60 doses given. LPN #3 had signed out 58 of the 60 doses as administered by her to Resident #9.An observation and interview with Licensed Practical Nurse (LPN) #2 on 2/24/26 at 8:50 AM, while preparing morning medications, revealed Resident #9 did not usually take pain medication. During medication administration, the resident stated, I don't want any pain medication.An interview with Licensed Practical Nurse (LPN) #4 on 2/24/26 at 4:26 PM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #9 had Tylenol and Norco available but had never reported pain or requested pain medication from her. She stated the resident was cognitively intact and capable of communicating pain needs. Review of the narcotic log with LPN #4 confirmed LPN #3 had repeated documentation of administering Norco multiple times daily when working.An additional interview with Resident #9 on 2/24/26 at 4:36 PM revealed he did not take pain medication, did not want pain medication, and denied pain. He stated, I think you have mixed me up with my roommate because he takes pain medication.Record review of Resident #9's February 2026 MAR revealed pain was monitored every shift. When Licensed Practical Nurse (LPN) #3 worked, pain scores were documented as 8-9 on a scale of 0-10 with 10 being the worst pain. On all other shifts, pain scores were documented as zero.An interview with Licensed Practical Nurse (LPN) #3 on 2/25/26 at 8:25 AM revealed Resident #9 had surgery a year ago and requested pain medication at that time. She verbalized she continued to administer it and stated the resident reported generalized pain all over. She stated he had no observable physical signs of pain or distress.Record reviews of the January and February 2026 Medication Administration Record (MARs) revealed 13 residents had active physician orders for PRN opioid pain medications, including Norco (12 residents) and Oxycodone (1 resident), requiring administration based on assessed pain. Further review of the MARs revealed pain scores were documented on all shifts.Record review of the January and February 2026 MARs for 13 residents receiving PRN pain medication revealed repeated documentation of administration to multiple residents at identical times on numerous dates across different rooms throughout both months by LPN #3. The highest cluster occurred on 2/21 and 2/22, where PRN pain medication was documented for 12 residents at 7:01 AM. This documentation did not reflect individualized assessment or real-time documentation of medication administration times.JANUARY 2026 MARMorning Administration Pattern 7:01 AM (0701)LPN #3 documented PRN pain medication administration at 7:01 AM for multiple residents on numerous January dates: 1/1 - 8 residents 1/2 - 8 residents 1/5 - 4 residents 1/6 - 8 residents 1/9 - 4 residents 1/10 - 8 residents 1/11 - 7 residents 1/14 - 4 residents 1/15 - 7 residents 1/19 - 4 residents 1/20 - 8 residents 1/23 - 5 residents 1/24 - 7 residents 1/25 - 6 residents 1/28 - 5 residents 1/29 - 7 residentsMid?Morning Administration Pattern 11:01 AM (1101)PRN pain medication was repeatedly documented at 11:01 AM, most commonly for 1-2 residents across the above January work dates.Midday Administration Pattern 12:31 PM (1231)Documentation at 12:31 PM showed repeated clustered administration: 1/1 - 6 residents 1/5 - 5 residents 1/6 - 4 residents 1/9 - 6 residents 1/10 - 5 residents 1/11 - 6 residents 1/14 - 6 residents 1/15 - 5 residents 1/19 - 6 residents 1/20 - 5 residents 1/23 - 4 residents 1/24 - 5 residents 1/25 - 5 residents 1/28 - 5 residents 1/29 - 4 residentsAfternoon Administration Pattern 3:01 PM (1501)Documentation at 1501 reflected repeated grouping of residents on many dates (commonly 2 residents).Evening Administration Pattern 6:31 PM- 6:46 PM (1831-1846)Evening administration times demonstrated clustered documentation within minutes apart reflecting multiple residents documented in close succession.FEBRUARY [DATE]Morning Administration Pattern 7:01 AM (0701)LPN #3 documented PRN pain medication administration at 7:01 AM for multiple residents on nearly every shift worked in February: 2/2 - 5 residents 2/3 - 8 residents 2/6 - 4 residents 2/7 - 9 residents 2/8 - 8 residents 2/11 - 4 residents 2/12 - 8 residents 2/16 - 5 residents 2/20 - 9 residents 2/21 - 12 residents 2/22 - 12 residents 2/25 - 5 residentsMid?Morning Administration Pattern 11:01 AM (1101)PRN pain medication was repeatedly documented at 11:01 AM, most commonly for 2 residents on multiple February dates.Midday Administration Pattern 12:31 PM (1231)Documentation at 12:31 PM showed repeated clustered administration: 2/2 - 6 residents 2/3 - 5 residents 2/6 - 5 residents 2/7 - 6 residents 2/8 - 6 residents 2/11 - 6 residents 2/12 - 5 residents 2/16 - 7 residents 2/20 - 6 residents 2/21 - 8 residents 2/22 - 9 residentsAfternoon Administration Pattern 3:01 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM (1501)Documentation at 1501 reflected repeated clustering: 2/2 - 2 residents 2/3 - 3 residents 2/11 - 2 residents 2/20 - 3 residents 2/21 - 4 residents 2/22 - 3 residentsEvening Administration Pattern 6:31 PM to 6:49 PM (1831-1849)Evening administration times demonstrated clustered documentation within minutes apart, frequently between 6:31PM to 6:49 PM (1831 and 1849), with multiple residents documented at consecutive minute intervals.A telephone interview with Licensed Practical Nurse (LPN) #3 on 2/27/26 at 9:13 AM revealed she administered all PRN pain medication during routine medication pass (morning, noon, and evening) and selected one set time for all residents (referring to repeated documented times of 7:01 AM and 12:31 PM) so residents could receive medication again depending on physician orders. LPN #3 confirmed the residents' medical records did not accurately reflect actual administration times. She stated she did not always ask residents about their pain and confirmed some pain level documentation was entered without asking the residents and she confirmed that she falsely documented the pain levels. She revealed she did not ask Resident #9 about pain and administered medication without the resident's consent. She confirmed she documented pain scores of 8 and 9 for Resident #9, which were inaccurate. She stated this was not how she had been trained to administer medication and should be charting the medications immediately after giving them. She confirmed that this practice was not in accordance with the standards of nursing practice.An interview with the Director of Nursing (DON) on 2/27/26 at 3:30 PM confirmed that after reviewing all 13 residents' MARs a pattern of documentation inconsistencies related to LPN #3 was identified. She stated the nurse had worked at the facility for 11 years and had prior medication documentation issues, for which a medication administration competency had recently been completed. Record review of LPN #3's Progressive Discipline Form dated 11/19/22 revealed under, Summary of Incident: Nurse failed to follow procedure for properly counting all narcotics at each shift change or relinquishing of narcotic keys. Copy of Controlled Substance Accountability Guide provided to nurse. Record review of LPN #3's Progressive Discipline Form dated 9/17/24 revealed under, Summary of Incident: Medication was found at bedside of 2 residents. Record review LPN #3's Progressive Discipline Form dated 5/8/25 revealed under, Summary of Incident: Lack of professionalism displayed by making inappropriate comments regarding upper management to other staff in regard to physical assistance in the building for coverage of open shifts. Copying and pasting of skilled notes. 1:1 to be performed on Monday 5/12/25 with Director of Nursing Services. Record review of the Proper Name of Pharmacy Services Monthly Consultant Review dated October 2025 revealed a Med pass observation - Med Preparation & MAR documentation audit was conducted with LPN #3. The nurse did not check meds against MAR prior to administering them, did not document them as administered directly after giving the meds to the patient.Record review of the Licensed Nurse Core Clinical Competency dated 12/4/25 revealed the Director of Nursing conducted a competency observation with LPN #3 on medication administration following pharmacist identified concerns with med pass in October 2025.Record review of LPN #3's Progressive Discipline Form dated 12/4/25 revealed medication competency checklist to be reviewed, completed with supervisor check off by 1/4/26.Record review of the In-services dated 2/26/25 revealed LPN #3 attended an in-service with the topics of narcotic destruction, cart organization, non-narcotic medication destruction. As part of the in-service LPN #3 received the following education Immediately after punching out narcotics to be administered, sign narcotic book. Then administer the medication to resident return to cart and sign out in EHR (electronic heath record)/EMAR (electronic medication administration record). Record review of the In-service with the topic of Medication Pass Guideline, dated 2/18/25 revealed LPN #3 attended the in-service dated 2/27/25. Record review of LPN #3's Course Completion History revealed the nurse complete an online course on documenting medications dated 11/16/25.Record review of the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission Record revealed the facility admitted Resident #9 on 10/17/23 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #9 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #12 on 8/10/21 with medical diagnoses that included Chronic Respiratory Failure.Record review of Resident #12's MDS with an ARD of 1/22/26 revealed under section C, a BIMS summary score of 15, indicating Resident #12 was cognitively intact. Record review of Resident #12's January and February 2026 Medication Administration Record (MAR) revealed an order dated 7/3/24: Norco oral tablet 7.5/325 mg (milligrams) give one (1) tablet by mouth every six (6) hours as needed for moderate pain.Record review of the admission Record revealed the facility admitted Resident #22 on 3/17/16 with a medical diagnosis that included Unspecified Dementia.Record review of the MDS with an ARD date of 12/12/26 revealed under section C, a BIMS summary score of 2, indicating Resident #22 was severely cognitively impaired. Record review of Resident #22's January 2026 MAR revealed an order dated 4/30/24: Norco oral tablet 10/325 mg give 1 tablet by mouth every 6 hours as needed for pain.Record review of the admission Record revealed the facility admitted Resident #27 on 8/6/25 with medical diagnoses that included Peripheral Vascular Disease.Record review of the MDS with an ARD of 2/13/26 revealed under section C, a BIMS summary score of 11, indicating Resident #27 was moderately cognitively impaired. Record review of Resident #27's January and February 2026 MAR revealed an order dated 8/11/25: Hydrocodone-acetaminophen oral tablet 7.5/325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain.Record review of the admission Record revealed the facility admitted Resident #38 on 2/9/23 with medical diagnoses that included Nonalcoholic Steatohepatitis.Record review of the MDS with an ARD date of 1/15/26 revealed under section C, a BIMS summary score of 15, indicating Resident #38 was cognitively intact. Record review of Resident #38's January and February 2026 MAR revealed an order dated 11/6/23: Norco oral tablet 7.5/325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain.Record review of the admission Record revealed the facility admitted Resident #43 on 2/13/26 with medical diagnoses that included Encounter for other Specified Surgical Aftercare.Record review of the MDS with an ARD of 2/19/26 revealed under section C, a BIMS summary score of 15, indicating Resident # 43 was cognitively intact. Record review of Resident #43's February 2026 MAR revealed an order dated 2/13/26: Hydrocodone-acetaminophen oral tablet 10/325 mg give 1 tablet by mouth every 6 hours as needed for pain.Record review of the admission Record revealed the facility admitted Resident #44 on 2/12/26 with medical diagnoses that included Pain and Type 2 Diabetes Mellitus without Complications.Record review of the MDS with an ARD of 2/18/26 revealed under section C, a BIMS summary score of 10, indicating Resident #44 was moderately cognitively impaired. Record review of Resident #44's February 2026 MAR revealed an order dated 2/13/26: Hydrocodone-acetaminophen oral tablet 5/325 mg give 1 tablet by mouth every eight (8) hours as needed for pain.Record review of the admission Record revealed the facility admitted Resident #47 on 10/21/21 with medical diagnoses that included Chronic Diastolic (Congestive) Heart Failure.Record review of the MDS with an ARD of 2/6/26 revealed under section C, a BIMS summary score of 11, indicating Resident # 47 was moderately cognitively impaired. Record review of Resident #47's January and February 2026 MAR revealed an order dated 2/19/25: Hydrocodone-acetaminophen oral tablet 10/325 mg give one tablet by mouth every four (4) hours as needed for moderate to severe pain.Record review of the admission Record revealed the facility admitted Resident #61 on 4/14/23 with medical diagnoses that included Adjustment Disorder with Mixed Anxiety and Depressed Mood.Record review of the MDS with an ARD of 1/14/26 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed under section C, a BIMS summary score of 14, indicating Resident #61 was cognitively intact. Record review of Resident #61's January and February 2026 MAR revealed an order dated 11/15/24: Norco oral tablets 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain.Record review of the admission Record revealed the facility admitted Resident #65 on 1/22/26 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side.Record review of the MDS with an ARD of 1/27/26 revealed under section C, a BIMS summary score of 6, indicating Resident #65 was moderately cognitively impaired. Record review of Resident #65's February 2026 MAR revealed an order dated 2/12/26: Hydrocodone-acetaminophen oral tablet 5/325 mg give 1 tablet by mouth every 6 hours as needed for pain.Record review of the admission Record revealed the facility admitted Resident #68 on 2/13/26 with medical diagnoses that included Cerebral Infarction.Record review of the MDS with an ARD of 2/19/26 revealed under section C, a BIMS summary score of 8, indicating Resident #68 was severely cognitively impaired. Record review of Resident #68's February 2026 MAR an order dated 2/18/26: Hydrocodone-acetaminophen oral tablet 5/325 mg give 1 tablet by mouth every 6 hours as needed for pain.Record review of the admission Record revealed the facility admitted Resident #95 on 12/12/24 with medical diagnoses that included Displaced Fracture of Base of Neck of Right Femur.Record review of the MDS with an ARD of 2/8/26 revealed under section C, a BIMS summary score of 9, indicating Resident # 95 was moderately cognitively impaired. Record review of Resident #95's January and February 2026 MAR revealed an order dated 12/12/24, Oxycodone oral tablet 5 mg give 1 tablet by mouth every 4 hours as needed for moderate to severe pain.Record review of the admission Record revealed the facility admitted unsampled Resident D on 2/20/26 with medical diagnoses that included Pressure Ulcer of Sacral Region. The resident transferred to the hospital and was discharged on 2/22/26 therefore, a BIMS summary score was not conducted. Record review of Unsampled Resident D's February 2026 MAR revealed an order dated 2/21/26: Hydrocodone-Acetaminophen oral tablet 10/325 mg give 1 tablet by mouth every 6 hours as needed for pain.