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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, record review, monthly pharmacy reviews, and facility policy review, the facility failed to ensure its pharmacy services and drug regimen review process identified and addressed irregularities in as needed (PRN) opioid medication documentation for 13 of 25 residents on medication cart B. Resident #9, #12, #22, #27, #38, #43, #44, #47, #61, #65, #68, #95 and unsampled Resident D. Findings Include:Review of the facility policy titled Drug Regimen Review reviewed 4/23, revealed under, Policy: Drug Regimen Review consists of a review and analysis of prescribed medication therapy and medication use, including nursing documentation, medication ordering, and administration. The Consultant Pharmacist reviews the medication regimen and medical record of each resident at least monthly. Recommendations and identified irregularities are reported in writing to the Director of Nursing, the Attending Physician, and the Medical Director.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).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 Licensed Practical Nurse (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 real-time documentation of medication administration times.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 Monthly Consultant Pharmacist Review dated December 2025, January 2026 and February 2026 revealed a drug regimen review was conducted for all the residents residing in the facility. MARS were reviewed for appropriate documentation along with an evaluation of PRN medication usage with documentation.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 interview with the Pharmacy Consultant, on 2/25/26 at 10:55 AM revealed that she came monthly and reviewed the medication dispensing machine, the medication rooms, the medication carts, did medication pass observations with the nurses, and conducted medication cart audits and narcotic log audits. She revealed that she did the monthly medication regimen reviews for the residents to ensure that PRN pain medication was documented accurately. She revealed that she did audit the narcotic log and stated that she had noticed one nurse (LPN#3) had signed out narcotics frequently and had made a note of this in her cover page in October 2025 and let the Director of Nursing (DON) know. She stated that she did a medication pass with LPN #3 in October, and during that time, she noted that the nurse did not compare the medications to the MAR prior to administering and she did not sign the medications out immediately after administering them. She revealed that they had not identified any (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic discrepancies or concerns with the PRN pain medications during the monthly regimen reviews conducted. But she did confirm that she had reviewed the Controlled Substance Inventory Record dated 12/04/25 for Resident #9 and had noted that LPN #3 had signed for 58 of the 60 doses and she had brought it up in her exit meeting with the Administrator and the DON.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 time. She stated this was not how she had been trained to administer medication and should be charting the medications immediately after giving them.An interview with the 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. The DON revealed the facility had not identified any pain medication irregularities with LPN #3 and confirmed that the facility failed to identify narcotic documentation irregularities.Record review of the 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 the 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 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 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 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 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 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 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 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 revealed under section C, a BIMS summary score of 14, indicating Resident #61 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #65 on 1/22/26 with medical (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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 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.

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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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review the facility failed to provide a safe, clean environment as evidenced by overbed tables with a thick black substance on the metal base for three (3) of sixty-three resident rooms observed. (room [ROOM NUMBER], #18, and #28) 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 .To receive services in a center environment that is safe, clean, and comfortable . On 2/23/2026, between 3:25 PM and 4:00 PM, observations on B Wing revealed that Rooms #16, #18, and #28 contained overbed tables with a thick black substance scattered across the metal bases. The condition was readily observable upon entering the residents' rooms.On 2/24/2026 at 1:30 PM, an observation and interview revealed the overbed table bases in Rooms #16, #18, and #28 remained coated with a thick black substance on the metal bases of both residents' overbed tables. Certified Nurse Aide (CNA) #6 stated the table bases appeared very rusty and in poor condition. CNA #6 reported staff are expected to notify nursing when equipment requires replacement, and nursing then notifies the maintenance department.On 2/25/2026 at approximately 2:15 PM, an observation and interview revealed the overbed tables in Rooms #16, #18, and #28 continued to have a thick black substance on the metal bases. CNA #2 stated that when staff identify items needing repair, a work order is submitted through the kiosk system to notify maintenance. CNA #2 stated she had not submitted a work order and had not noticed the condition of the overbed tables.On 2/25/2026 at 3:35 PM, the Director of Nursing (DON) confirmed the overbed tables in Rooms #16, #18, and #28 had a thick black substance on the metal bases. The DON stated the tables looked bad and did not represent a homelike environment.On 2/26/2026 at 9:11 AM, the Maintenance Supervisor stated he receives repair notifications through an electronic work order system. He reported he was unaware of any work orders submitted for cleaning or replacement of the overbed tables. He further stated that upon inspecting B Wing, he observed multiple overbed tables that were rusted and in need of replacement.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and family interview, record review, and facility policy review, the facility failed to ensure a resident who was dependent on staff for incontinent care received timely assistance with activities of daily living (ADLs) for one (1) of 25 sampled residents. Resident #18Findings Include:Review of the facility policy titled ADL's (Activities of Daily Living) dated 2025 revealed under, Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences .An interview with a family member on 2/24/26 at 2:10 PM revealed she entered the facility around 1:05 PM to visit Resident #18, whose call light was sounding because she was wet and needed to be changed. The family member stated that when second shift (2PM-10PM) Certified Nursing Assistants (CNAS) came in, Resident #18 was extremely soiled to the extent that the brief was saturated, appeared brown in color, and the bed sheets were wet. She further stated the resident had a bowel movement in her brief and waited over one hour to be changed. The family member reported this had been an ongoing issue with day shift not changing the resident timely and stated she had complained to administration the previous week.An interview with evening shift (2PM-10PM) CNA's #3 and #4 on 2/24/26 at 2:18 PM revealed that when they came on shift, Resident #18's call light was on. CNA #3 stated they both entered the room and changed the resident. CNA #3 and #4 confirmed the resident was soaked in urine, had a bowel movement, and had wet the bed sheets. Both aides confirmed this was an ongoing issue when coming in behind day shift and stated they did not make rounds timely to ensure residents were kept clean and dry. CNA #4 stated the resident was not a heavy wetter and that when rounds were made every two hours, as expected, this did not occur.An interview with Registered Nurse (RN) #3 on 2/24/26 at 2:32 PM revealed she observed the resident's call light on, went to the room, and answered the light. The family member notified her the resident was wet. RN #3 stated she turned the call light off and went across the hall to locate CNA #5, who was busy, so she returned and notified the resident it would be a minute. She explained the call light came on again later, so she returned to the room and found the resident was still waiting to be changed. She then checked again with the assigned aide, who was still busy, and returned to notify the resident the aide would be there shortly. RN #3 stated the call light came on again and she observed the aide walking down the hall away from the room. She confirmed the aide never addressed Resident #18's needs and by that time second shift had come in. RN #3 confirmed timely incontinent checks should be completed every two hours and as needed and that the resident should not have been left soiled which could cause skin breakdown.A telephone interview with Certified Nurse Aide (CNA) #5 on 2/26/26 at 10:46 AM revealed she was across the hall giving another resident a bath when Resident #18's call light was going off. She stated she could not stop what she was doing to address the residents' needs. CNA#5 revealed the last incontinent round completed for Resident #18 was around 10:00 AM and confirmed rounds should be made every two hours and as needed. She stated she entered the room before the end of her shift; however, tensions were high and the family member was upset, so she left to allow the situation to de-escalate. She stated the evening shift agreed to change Resident #18 and she confirmed that she left the resident soiled.An interview with the Director of Nursing (DON) on 2/26/26 at 3:30 PM confirmed that any staff member could provide incontinent care to a resident and further confirmed expectations were that rounds should be made every two hours and as needed.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 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed under Section C a Brief Interview for Mental Status (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure residents were protected from accident hazards related to unsafe possession and storage of smoking materials for three (3) of nineteen residents identified as smokers. (Resident #88, Unsampled Residents A, and B)Findings Include:Review of the Facility policy titled Safe Tobacco Use with a revision date of November 3, 2022, revealed under, Purpose: 1. To maximize our ability to provide a safe environment for all residents/patients who smoke, while taking into account non-smoking residents. 4. Staff members will monitor or obtain fire igniting materials (matches/lighters) for the benefit of smokers at the nurses' station or other designated location .On 2/23/2026 at 11:30 AM, an observation revealed a gray box of cigarettes lying on the chest of drawers near the television in Resident #88's room.On 2/24/2026 at 9:45 AM, an observation and interview revealed two (2) boxes of cigarettes and a red lighter lying on Resident #88's bedside table, and one (1) additional box of cigarettes on the chest of drawers. Resident #88 stated, I can have my cigarettes and lighter in my room. I had them in my vest pocket when I came back from smoking. I usually put them on my bookcase, but I just laid them on my table this time.On 2/24/2026 at 3:00 PM, during scheduled smoke break time, observations and interviews revealed three (3) unsampled residents seated in the hallway near the exit door to the outside smoking area. Unsampled Resident A was seated in her wheelchair with a cigarette box visible in her cup holder and stated, We can keep our cigarettes and lighters with us. Unsampled Resident B, also seated in her wheelchair, stated she always keeps her cigarettes with her and takes them to her room.On 2/24/2026 at 3:30 PM, the Director of Nursing (DON) stated the facility expectation is that residents do not keep cigarettes or lighters on their person. The DON stated smoking materials are to be kept in a locked box and provided to residents at designated smoke times. The DON acknowledged residents sometimes obtain and keep cigarettes and lighters despite this expectation and stated that staff attempts to confiscate the items when observed.On 2/24/2026 at 3:40 PM, the Administrator stated the facility attempts to prevent residents from keeping cigarettes and lighters; however, she confirmed she has observed residents in possession of these items. She revealed the facility is attempting to address the issue through care planning and family education and acknowledged the presence of smoking materials constitutes an accident hazard. The Administrator further stated staff conduct morning room rounds and are expected to notify administration if smoking materials are observed.Record review of the admission Record revealed the facility admitted Resident #88 on 3/10/25 with medical diagnoses that included Emphysema, Atrial Fibrillation and Atherosclerotic Heart Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/3/2025 revealed under section C, A Brief Interview for Mental Status (BIMS) summary score of 15, which indicates Resident #88 is cognitively intact. Record review of the admission Record revealed the facility admitted unsampled Resident A on 1/7/2025 with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Nicotine Dependence. Record review of the MDS with an ARD of 12/24/2025 revealed under section C, A BIMS summary score of 15, which indicates unsampled Resident A is cognitively intact. Record review of the admission Record revealed the facility admitted unsampled Resident B on 11/28/2021 with medical diagnoses that included Parkinson's Disease without Dyskinesia, and Major Depressive Disorder. Record review of the MDS with an ARD of 1/29/2026 revealed under section C, A BIMS summary score of 15, which indicates unsampled Resident B is cognitively intact.

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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, staff interview, and facility policy review, the facility failed to ensure a medication cart was secured to prevent unauthorized access for one (1) of four (4) medication carts observed (B Wing). Findings Include: Review of the facility policy titled, Proper Name, Inc. Policies and Procedures, revised 04/22, stated, It is the responsibility of the facility to keep the medication cart locked and secure at all times when not in use . During an observation on 2/24/26 at 2:35 PM, the medication cart on B Wing was observed unlocked and unattended. Licensed Practical Nurse (LPN) #2 stated she got busy and forgot to lock her cart before sitting down to chart. She stated the cart should always be secured for the safety of the residents. On 2/25/26 at 2:30 PM, an interview was conducted with the Director of Nursing (DON), who stated medication carts should never be left unlocked when not in use. She stated medication carts are to be locked at all times when not in use for the safety of the residents.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy reviews, the facility failed to implement infection prevention and control practices to prevent the transmission of infections. Specifically, the facility failed to ensure oxygen delivery devices were stored in a sanitary manner when not in use for one (1) of four (4) days of survey and failed to ensure staff used Enhanced Barrier Precautions (EBP) during wound care during 1 of 4 resident care opportunities. (Residents #3 and #12) Findings include: Resident #3 Review of manufacture's guidelines titled (Proper Name) product guidelines for resp (respiratory) O2 (oxygen) tubing with no date, revealed, .Environmental Storage and Protection, For tubing not currently in use, containment should protect the material from degradation:.it should be contained in a clean, sealed plastic bag or container to protect it from dust, pet dander, and other contaminants. During observations on 2/23/2026 at 10:45 AM and again at 3:41 PM, Resident #3's oxygen tubing was lying on the floor at both observation times. During an interview on 2/23/2026 at 3:42 PM, Registered Nurse (RN) #1 confirmed the tubing should not be on the floor and stated it should be stored in the bag attached to the concentrator. She identified the tubing lying on the floor as an infection control concern. During an interview on 2/24/2026 at 1:45 PM, with the Director of Nursing (DON) confirmed each oxygen concentrator has a bag attached and that oxygen tubing should be stored in the bag when not in use. She further stated oxygen tubing lying on the floor was an infection control concern and placed Resident #3 at increased risk for infection. Record review of the admission Record revealed Resident #3 was admitted to the facility on [DATE] with medical diagnoses that included Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident had moderate cognitive impairment. Resident #12 Review of the facility's Infection Control Guide, dated 2025, revealed under Enhanced Barrier Precautions (EBP), The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices. An observation and interview with Resident #12 on 2/23/26 at 10:44 AM revealed a sign outside the resident's doorway that indicated EBP. The resident stated he had orthopedic hardware exposed through the skin of his right ankle from an old injury that occurred 22 years ago. He revealed he had been on antibiotics off and on and had been hospitalized for sepsis, with the doctor recommending hardware removal. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's Treatment Administration Record revealed an order dated 2/8/26: Other erosion to right medial ankle - Clean wound with wound cleanser, pat dry with gauze, apply zinc oxide ointment 20% (percent) to peri wound, apply Mupirocin (antibiotic) ointment 2% (percent) to wound bed and cover with a folded 4 x (by) 4 gauze, ABD (abdominal) pad, wrap with kerlix and secure with tape every day shift for exposed surgical hardware. An observation of wound care with the Assistant Director of Nursing Services (ADNS) on 2/24/26 at 4:02 PM revealed she did not apply a gown for Enhanced Barrier Precautions (EBP) while providing wound care. An interview with the ADNS on 2/24/26 at 4:16 PM confirmed the resident was on EBP due to an open wound and acknowledged she did not wear a gown. She further revealed the purpose of the precautions was to protect the resident from getting an infection. Record review of the admission Record revealed the facility admitted Resident #12 on 8/10/21 with medical diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia, Presence of Right Artificial Ankle Joint, and Local Infection of the Skin and Subcutaneous Tissue. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #12 was cognitively intact.