

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2021
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF TUPELO			STREET ADDRESS, CITY, STATE, ZIP CODE 2273 SOUTH EASON BOULEVARD TUPELO, MS 38804		
(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	
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.1, 7.1.10.1. This standard deficiency affected one (1) of six (6) exits and 24 of 84 residents in the facility on the day of survey. Findings include: On 5/4/21 at 10:15 AM, observation revealed furniture, carts, and pallets blocking the exit and exit discharge (corridors/ hallways) from the Front exit and the C Hall of the facility. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 211	-All furniture, carts and pallets that was blocking the exit and exit discharge (corridors/hallway) from the front exit and C hall was removed immediately and 5/04/21 upon discovery by our Maintenance Director. -All residents have the potential to be affected by this alleged deficient practice. The maintenance Director or Maintenance assistant will monitor all exits and exit discharges five (5) times a week for three (3) weeks to ensure that exits are not blocked. (See Exhibit A) -Education was started on 5/06/21 by the Director of Clinical Education and Maintenance Director on Aisles,	7/6/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/02/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2021
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF TUPELO			STREET ADDRESS, CITY, STATE, ZIP CODE 2273 SOUTH EASON BOULEVARD TUPELO, MS 38804		
(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	
K 211	Continued From page 1	K 211	passageway's corridors, exit discharges, exit locations, accesses and the means of egress being free of all obstructions to full use in case of emergencies. (Exhibit B) -Systemic changes will include rounds (five) 5 times a week by the Maintenance director or Maintenance assistant for twelve (12) weeks or until sustained compliance can be achieved to ensure that all exits and exit discharges are not blocked. (Exhibit A) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. (Exhibit D)		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to	K 374	-The door closure on the smoke barrier	7/6/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2021
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF TUPELO			STREET ADDRESS, CITY, STATE, ZIP CODE 2273 SOUTH EASON BOULEVARD TUPELO, MS 38804		
(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	
K 374	Continued From page 2 provide 20-minute fire resistance rating smoke barrier door in accordance with NFPA 101 sections 19.3.7.6, 19.3.7.8, 19.3.7.9. This standard deficiency affected 14 of 84 residents in the facility on the day of survey. On 5/4/21 at 11:15 AM, observation revealed the smoke barrier door near Therapy Unit of the facility did not properly close and latch upon activation of the fire alarm and sprinkler systems. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 374	door near Therapy was adjusted on 05/04/21 by our Maintenance Director immediately upon discovery to ensure that it closed properly and latched upon activation of the fire alarm and sprinkler systems. A new closure was ordered and upon receipt on 05/21/2021 was placed on the smoke barrier door near Therapy. (Exhibit E) -All residents have the potential to be affected by this alleged deficient practice. The Maintenance Supervisor or Maintenance assistant will monitor all smoke barrier doors to ensure that they close properly and latch upon activation of the fire alarm and sprinkler systems three (3) times a week for three (3) weeks. (Exhibit F) -Education was started on 05/06/2021 by the Director of Clinical Education and Maintenance Director on ensuring that all smoke barrier doors close properly and latch upon activation of the fire alarm and sprinkler systems. (Exhibit B) -Systemic changes will include rounds one (1) time a week by the Maintenance Director or Maintenance assistant for twelve (12) weeks or until sustained compliance can be achieved to ensure that all smoke barrier doors close properly and latch upon activation of the fire alarm and sprinkler systems (Exhibit F) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee monthly for		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2021
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF TUPELO			STREET ADDRESS, CITY, STATE, ZIP CODE 2273 SOUTH EASON BOULEVARD TUPELO, MS 38804		
(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	
K 374	Continued From page 3	K 374	three (3) months. (Exhibit D)		