

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #28953 and CI MS #29165) at the facility on 6/17/25 through 6/18/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F755 for both complaints for pharmacy services. The census at the time of the survey was 110 with a license for 119 beds.	F 000			
F 755 SS=E	Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		7/21/25	

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

TITLE

(X6) DATE

Electronically Signed

07/03/2025

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: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident representative interviews, staff interviews, record review, and facility policy review, the facility failed to provide pharmacy services for obtaining medications timely for two (2) of four (4) residents sampled. Resident #1 and Resident #2 Findings include: Record review of facility's letterhead titled, "Standards of Practice", undated, revealed, "The expectation set forth by (facility's name) management is that nurses comply with current standards of practice in terms of following physician's orders". Record review of facility policy titled, "Resident Rights and Quality of Life Policy", dated 3/13/20, revealed, "It is the policy of (facility's name) 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 #1 During a phone interview on 6/17/25 at 12:10 PM, Resident #1's Representative (RR) revealed the	F 755			

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 2 resident was admitted to the facility on the evening on 5/13/25 and was sent to the hospital on 5/14/25 around 10:00 PM. He was admitted with a foot infection and Chronic Obstructive Pulmonary Disease (COPD) and was on medications for these conditions. RR stated he was uncertain if the resident received the medications and treatments needed for his infection and his lung illness prior to him returning to the hospital on 05/14/25. During a phone interview on 6/17/25 at 3:26 PM, Licensed Practical Nurse (LPN) #1 revealed she had worked with Resident #1, and he had shortness of breath and she administered his as needed respiratory treatments around 3:00 AM and 9:00 PM which were effective. After his 9:00 PM treatment, he complained of chest pain, provider was notified, nitroglycerin was ordered and administered, and resident was sent to the hospital by ambulance. She revealed she was uncertain of any other medications received by the resident on admission. She revealed some medications were in the medication system in the facility, but others came from the pharmacy and if pharmacy had already brought meds to the facility, they would bring the ordered meds the next day. Record review of Resident #1's hospital "Discharge Summary" dated 5/13/25 revealed diagnoses of postoperative wound infection and osteomyelitis of left foot. Review revealed resident was discharged to facility on Vancomycin. Record review of Resident #1's discharge "Medication List" from hospitalization dated 5/13/25 at 2:53 PM, revealed Vancomycin every	F 755			

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 3 12 hours. Record review of "Progress Note" dated 5/13/25 at 5:26 PM, revealed, "Resident received to facility via (by) wheelchair van from (local hospital) in wheelchair accompanied via relative. Wound vac to left foot, resident non-weight bearing, morbidly obese. Able to make needs known with clear speech." Record review of "Order Summary Report" revealed an order for Vancomycin one gram intravenously (IV) two times a day related to acute osteomyelitis of left ankle and foot. Record review of Electronic Medication Administration Record (EMAR) revealed the resident did not receive the 5/13/25 evening dose or the 5/14/25 morning dose of Vancomycin as ordered. Record review of "Discharge Summary" for hospitalization dates of 5/14/25 through 5/15/25 revealed "Reason for Hospitalization" was COPD exacerbation. Record review of Resident #1's "Admission Record" revealed he was admitted on 5/13/25 with diagnoses that included Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Infection of the skin and subcutaneous tissue, disruption of external operation surgical wound. Record review of Resident #1's Minimum Data Set (MDS) dated 5/14/25 did not reveal a Brief Interview for Mental Status (BIMS) score with reason being resident is rarely/never understood. Resident #2	F 755			

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 4 During a phone interview on 06/17/25 at 1:15 PM, Resident #2's Representative revealed the resident was admitted to the facility from the hospital on 5/27/25 and she stated he was in the hospital for seizures and pneumonia and was on medications for both conditions and these medications were to be continued during the facility stay. She was uncertain if he received his antibiotics for pneumonia and his other medications that the hospital ordered. On 5/31/25, Resident #2 was difficult to arouse and was sent to the hospital. Record review of Resident #2's "Discharge Summary" dated 5/27/25 revealed discharge diagnoses of status epilepticus and acute respiratory failure. Record review also revealed he was discharged with five more days of antibiotics for aspiration pneumonia. The discharge summary revealed "Medication List at Discharge" which included Amoxicillin and Clavulanate Potassium two times daily. Record review of Resident #2's "Discharge Summary" with admission date of 5/31/25 revealed resident was admitted to the hospital due to aspiration into airway and sepsis with acute hypoxic respiratory failure. Record review of Resident #2's "Order Summary Report" revealed an order dated 5/27/25 for Amoxicillin and Clavulanate Potassium (Augmentin) two times daily. Record review of Resident #2's Electronic Medication Administration Record (EMAR) revealed resident did not receive the evening dose of Augmentin on 5/27/25.	F 755			

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 5 During an interview with the Director of Nursing (DON) on 6/18/25 at 3:00 PM, she revealed if a resident is admitted in the late afternoon, the medications might not arrive from the pharmacy until the next day. A medication dispensing system is available in the facility with some medications, but other medications have to come from the pharmacy which was not local. The orders from the hospital are received prior to the arrival of the resident and are entered into the facility's system by the unit manager. If these medications are entered after a certain time, the system puts the start time for the next day, but the medication start time could be entered manually to prompt the nurse to administer the medication. The DON acknowledged that Resident #1 had orders for respiratory medication and antibiotics and he did not receive these as ordered. The DON acknowledged that Resident #2 had orders for antibiotics for pneumonia that he did not receive as ordered. She stated it was the nurses' responsibility to obtain information as to when the dose was last given at the hospital, administer medications as ordered, monitor the residents for any change in condition, and to notify the provider for concerns. An interview with the Administrator on 6/18/25 at 3:30 PM, revealed the facility admitted residents from the hospital without the needed medications and pharmacy services to provide physician ordered medications to the residents timely. Resident #1 did not receive the ordered Vancomycin and Resident #2 did not receive the ordered Augmentin. These medications were not available in the facility's medication dispensing system and had to be delivered to the facility from the pharmacy which was not local. She	F 755			

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

PRINTED: 07/10/2025
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
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	
F 755	Continued From page 6 acknowledged that not receiving medications timely and missing doses of medications could lead to complications for the residents. She confirmed that residents were admitted to the facility with specific medication orders and the facility failed to provide pharmacy services to obtain and administer these medications timely for Resident #1 and Resident #2.	F 755			