STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255105	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD , TUPELO, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an investigation of a facility reported incident (Incident # 2573436) at the facility on 8/11/25. During the survey the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F 689. The SA investigated abuse and accidents and hazards. The facility held a license for 119 beds, with a census of 106.	F0000		08/20/2025
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure that staff followed the resident's Kardex requiring two-person assistance for bed mobility and toileting. This failure resulted in Resident #1 falling from the bed and sustaining actual harm in the form of a skin tear, facial swelling, bruising, and maxillary hematoma, with increased pain requiring a new order for tramadol, an opioid analgesic, for one (1) of three (3) residents reviewed for accidents. (Resident # 1) Findings include: Review of the facility policy titled, "Resident Rights & Quality of Life Policy," with an effective date of	F0689	Resident #1 was assessed post fall by the nurse and provided care for injuries on 07/25/2025. Findings were communicated to the Medical Provider with new orders implemented by the center on 07/25/2025. Review of resident #1 care plan was completed and updated accordingly on 07/25/2025 by the interdisciplinary team. Certified Nursing Assistant #1 trained on July 30, 2025 by Director of Nursing and Director of Clinical Education and demonstrated competency in location of Kardex and verbal knowledge of following plan of care. Residents receiving staff assistance have the potential to be affected. Education initiated on 08/18/2025 by Director of Clinical Education with Certified Nursing Assistants to review the resident kardex for resident plan of care and needs. The Director of Nursing or team member will make observations of three Certified Nursing Assistants to include various shifts to ensure competency in location of Kardex for following resident plan of care five times a week for four weeks beginning 08/21/2025 then three times a week for three weeks, then twice a month for two months to assure compliance. All variances will be immediately corrected and addressed in Quality Assurance and Performance Improvement. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary team in Quality Assurance and Performance Improvement 08/25/2025 monthly times three months.	08/29/2025

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 reverse for further 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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F0689 SS = G	Continued from page 1 March 13,2020, revealed Procedure: A patient or resident has the right: … To receive services in a center environment that is safe. … Record review of the “Post Fall Review” for Resident #1 dated 7/25/25 revealed an investigation of the residents fall with an injury that indicated in an Interdisciplinary Team (IDT) Review: IDT met: “CNA (Certified Nurse Assistant) was in the room changing resident. Resident rolled over to be cleaned, reached for his over bed table and rolled off. Staff informed that resident requires (2) two persons assist with incontinent care.” A phone interview with the Director of Nursing (DON) on 8/11/25 at 11:08 AM confirmed that Resident #1 required a two person assistance for bed mobility and incontinent care and CNA #1 failed to provide care according to the Kardex resulting in the resident falling off of the bed obtaining a skin tear to the buttocks and bruising and swelling to the right side of the face. She also confirmed that Resident #1s Kardex read two persons assist for bed mobility and toileting on 7/25/25 the day of the incident. She admitted that the injuries from the fall resulted in increased pain for Resident #1 and the need for a new order for tramadol for pain. Record review of a computed tomography (CT) scan of the facial bones for Resident #1 dated 7/29/25, revealed Impression “ Small right maxillary subcutaneous hematoma.” … Record review of the Kardex Reports for Resident #1 from 7/22/25-7/25/25 revealed ADL (activity of daily living) Assistance: Extensive assist with bed mobility x 2 (two). …Extensive assist x 2 (two) with toilet use. … Record review of the July 2025 Medication Administration Record (MAR) for Resident #1 revealed Tramadol 50 mg (milligrams) give one tablet by mouth every six hours as needed for pain ordered 7/25/25 and he received six doses of tramadol from 7/25/25-7/28/25. Further review revealed Resident #1 had only received one dose of Tylenol 325 mg, two tablets for pain in the month of July prior to the fall on 7/25/25. An interview with CNA #1 on 8/11/25 at 12:00 PM confirmed that she was turning Resident #1 over to provide incontinent care on 7/25/25, stating the resident turns with one to two staff “depending on his mood.” She stated that as she was turning the resident, he reached over toward his bedside table and fell off	F0689		

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F0689 SS = G	Continued from page 2 the bed. She confirmed she was required to review each resident's Kardex to know the required care and that she believed the Kardex read one-to-two-person assist with bed mobility. An interview with CNA #2 on 8/11/25 at 12:10 PM revealed she had been working at the facility for about a month and had cared for Resident #1. She confirmed she was trained to follow the Kardex and stated Resident #1 required two-person assistance since she had been working with him. An interview with CNA #3 on 8/11/25 at 12:15 PM revealed they are to follow the Kardex to provide appropriate care. She stated she has been assigned to Resident #1 and confirmed he required two-person assistance for bed mobility and incontinent care because he is contracted. An interview with the Administrator (ADM) on 8/11/25 at 2:00 PM confirmed that after review of the Kardex for Resident #1 from 7/22/25-7/25/25 the date of the incident that the Kardex for Resident #1 read extensive assistance of (2) two for bed mobility and toileting and staff failing to do so resulted in the accident. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 11/10/2015 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominate side. Record review of Resident #1s Section G (Activities of Daily Living) of the Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of 7/15/25 revealed "Support" Bed mobility: was coded two-person physical assist. …Toileting: was coded two-person physical assist. …	F0689		