STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	**1901 BRIAR RIDGE ROAD , 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 annual re-certification survey at the facility from 12/8/25-12/11/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited F550, F578, F641, F656, F689, F692, F808, and F880. The census at the time of the survey was 103 and the facility is licensed for 120 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure resident privacy was maintained during medication administration for a resident with a gastrostomy tube for one (1) of six (6) care opportunities observed. Resident #16 Findings Include: Review of the facility policy titled “Dignity” with a revision date of 2/21 revealed under, “Policy Interpretation and Implementation: … 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.” An observation during medication pass on 12/10/2025 at 8:15 AM with Licensed Practical Nurse (LPN) #3 revealed she administered medications to Resident #16 via a gastrostomy tube while the room blind was half open, allowing the resident to be visible from the back parking lot and compromising the resident’s bodily privacy. An interview with LPN #3 on 12/10/25 at 8:32 AM confirmed the window blind was left open while administering medications to Resident #16 and revealed this was a privacy concern for the resident as his stomach and tube were visible to the people outside the window. An interview with the Director of Nursing (DON) on 12/10/25 at 10:48 AM revealed that residents were expected to be provided privacy during care and confirmed this was a dignity concern.	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0550 SS = D	Continued from page 2 Record review revealed the facility admitted Resident #16 on 6/07/24 with medical diagnoses including Unspecified Sequalae of Cerebral Infarction and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 12, indicating Resident #16 was moderately cognitively impaired.	F0550		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0578 SS = D	Continued from page 3 representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, record review, and facility policy review, each resident had the right to determine their end-of-life care and the facility failed to ensure the desired code status of the resident was reflected in the documentation for one (1) of 23 sample residents reviewed. Resident #10 Findings include: Record review of the facility policy titled, "Advance Directives", undated, revealed, "It is the policy of the facility to respect the resident's right of self-directed care including the right to issue Advance Directives on health care, to refuse or accept treatment, to make informed decisions, and/or appoint a health care agent to make decision on the behalf of the resident when the resident lacks the capacity to do so. 1. Each competent adult has the right to control his or her own health care decisions." Record review of facility policy titled, "Resident Rights" dated December 2016, revealed, "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... self-determination". Record review of Resident #10's "Consent for Cardiopulmonary Resuscitation", undated, revealed, "I understand that CPR (Cardiopulmonary Resuscitation) constitutes an extraordinary measure and SHOULD NOT be done on this resident". This was signed by the resident's representative. Record review of Resident #10's "Do Not Resuscitate" consent revealed the document was undated and signed by the resident's representative and the physician and indicated "Resuscitation would be medically futile". Record review of Resident #10's electronic "Order Listing Report" revealed an order dated 11/19/25 for a "full code". Record review of Resident #10's "Physician Telephone Order" dated 11/3/25 revealed, "Patient is a full code". During an interview on 12/9/25 at 1:40 PM, the Director of Nursing (DON) revealed each resident had the right to choose their end-of-life care and this choice was required to be properly documented to ensure the resident's desired end-of-life care would be honored. She acknowledged the physician's orders indicated a full code status. She acknowledged the "Consent for Cardiopulmonary Resuscitation (CPR)"	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0578 SS = D	Continued from page 4 signed by the resident's representative indicated that CPR should not be done and the "Do Not Resuscitate" form was undated and signed by the resident's representative and the physician revealed "Resuscitation would be medically futile". She acknowledged the documentation should reflect the resident's wishes for their end-of-life care and inaccurate documentation could lead to the resident's desires not being honored. She confirmed the facility failed to ensure the resident signed the consent for end-of-life care and failed to ensure the accuracy of the documentation for Resident #10's end-of-life care, which had the potential for the resident's desire to not be honored. An interview with Resident #10 on 12/9/25 at 3:05 PM, revealed she desired a full code status and was capable of signing her documents for this. An interview with the Administrator on 12/10/25 at 2:00 PM revealed each resident had the right to choose their end-of-life care and the documentation should be accurate and reflect the resident's wishes. She acknowledged the undated "Consent for Cardiopulmonary Resuscitation" signed by the resident's representative indicated CPR should not be done on this resident and the "Do Not Resuscitate (DNR)" consent, undated and signed by the resident's representative and the physician indicated a DNR status. She acknowledged the written order dated 11/3/25 and the electronic order dated 11/17/25 both indicated a full code status. She confirmed the facility failed to accurately document the resident's desire for end-of-life care which could have led to the resident's wishes not being honored. Record review of Resident #10's "Admission Record" revealed the facility admitted resident originally on 11/20/24 with the most recent admission date of 11/3/25. Diagnoses included Type 1 Diabetes Mellitus. Record review of Resident #10's Minimum Data Set (MDS) dated 10/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F0578		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0641 SS = D	Continued from page 5 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete section K of the Minimum Data Set (MDS) for one (1) of 23 minimum data sets reviewed. Resident #100. Findings Include: Review of the facility policy titled “Certifying Accuracy of the Resident Assessment” undated, revealed under, “Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment.” Record review of the “Weights and Vitals Summary” for Resident #100 revealed the following documented weights: 10/08/25 252 pounds	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0641 SS = D	Continued from page 6 10/28/25 252 pounds 11/03/25 249.6 pounds 11/13/25 230.8 pounds 11/18/25 230.7 pounds Record review revealed Resident #100 has a significant weight loss of 21 pounds and -8.3% (percent) in 1 month. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed under section K0300, Resident #100 did not have a weight loss of 5 % (percent) or more in the last month, which was inaccurate. An interview with the MDS Nurse on 12/11/25 at 7:58 AM revealed she was responsible for completing section K of the MDS. She confirmed she made an error on Resident #100's MDS and stated weight loss should have been coded. Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #100 on 7/12/21 with medical diagnosis that included Chronic Combined Systolic and Diastolic Heart Failure. Record review of the "Progress Notes" for Resident #100 dated 11/20/25, revealed a Brief Interview for Mental Status (BIMS) Evaluation was not conducted due to resident is rarely/never understood." Record review of the Admission Record revealed the facility admitted Resident #100 on 7/12/21 with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure.	F0641		
F0656 SS = G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0656 SS = G	Continued from page 7 measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to implement a fall care plan for Resident # 3 and failed to implement a fluid restriction care plan for Resident #87 for two (2) of 23 care plans reviewed.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0656 SS = G	Continued from page 8 Findings Include: Review of a facility policy titled, “Goals and Objectives, Care Plans,” last revised September 2013, revealed the policy statement indicated that care plans shall incorporate goals and objectives that lead to the resident’s highest obtainable level of independence. An observation conducted on 12/10/25 at 8:30 AM revealed Resident #3 in bed with three-quarter length side rails raised on both sides of the bed. Record review of a care plan titled, “I am at high risk for falls related to impaired mobility and unawareness of safety precautions,” initiated 9/5/24 and last revised 2/28/25, revealed interventions included use of three-quarter length side rails as enablers to assist with turning and repositioning while in bed, with instructions to release and reposition every two hours and as needed. Record review of an accident report dated 10/29/25 revealed staff heard yelling from down the hall. Upon entering the room, staff observed Resident #3 lying under the bedside table beside the bed. The resident’s right leg was wrapped in a blanket, skin tears were noted to both elbows, and the resident complained of right hip pain. The resident stated, “Yeah, I think it’s broke,” and further stated he “rolled out of bed during sleep.” Record review of Emergency Department records dated 10/29/25 revealed Resident #3 was diagnosed with a closed comminuted intertrochanteric fracture of the proximal end of the right femur. On 12/10/25 at 9:00 AM an interview with Resident #3 revealed he confirmed experiencing a fall in October when he rolled out of bed during the night because his side rail was not raised. On 12/10/25 at 10:10 AM a phone interview with Certified Nurse Assistant (CNA) #1 revealed she confirmed the left side rail was not raised when she entered Resident #3’s room following the fall in October 2025. On 12/10/25 at 9:11 AM an interview with the Director of Nursing revealed that, upon investigation of Resident #3’s fall from bed on 10/29/25, it was her understanding that the resident’s side rail was not in the raised position at the time of the fall and it should have been.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0656 SS = G	Continued from page 9 Review of the fall care plan with the Clinical Minimum Data Set (MDS) Nurse on 12/10/25 at 11:00 AM revealed she confirmed the fall care plan was not implemented when Resident #3's side rail was not raised at the time of the fall. She further stated the resident was to have three-quarter length side rails bilaterally to assist with turning and repositioning while in bed. Record review of the Admission Record revealed Resident #3 was admitted on 10/9/24 with diagnoses including acquired absence of the left leg above the knee and other reduced mobility. Record review of the Brief Interview for Mental Status (BIMS) score dated 11/8/25 revealed a score of 9, indicating the resident was moderately cognitively impaired. Resident #87 Review of Resident #87's "Care Plan Report" revealed under, "Focus: I am at risk for complications d/t (due/to) renal dialysis with fluid restrictions r/t (related to) renal failure." Further revealed under, "Interventions/Task: 900 CC (cubic centimeter) fluid restriction- breakfast-200 lunch -200 dinner- 200 medications – 200 snacks -100". Record review of Resident #87's December 2025 Medication Administration Record (MAR) revealed an order dated 7/16/25, "Record fluid intake in 24 hours. 900 cc (cubic centimeter) fluid restriction – Breakfast 200, Lunch 200, Dinner 200, Medications 200, Snacks 100." Review revealed there was no documentation of fluid intake amounts recorded, and the MAR was only initialed by the nurse. Record review of Resident #87's December 2025 "Flowsheet" revealed there was no evidence that fluid intake was monitored or documented. On 12/10/25 at 11:32 AM, an interview with the Director of Nursing (DON) revealed fluid restrictions were to be tracked on the MAR and totaled at the end of each shift and the DON confirmed this was not done for Resident #87. An interview with the Minimum Data Set (MDS) Nurse on 12/11/25 at 8:15 AM revealed the purpose of the care plan was so that staff knew what care to provide. She confirmed the care plan was not followed for Resident	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0656 SS = G	Continued from page 10 #87 since staff were not tracking and documenting fluid intake. Record review of the Admission Record revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the MDS with an ARD of 11/02/25 revealed under Section C, a BIMS summary score of 15, indicating Resident #87 was cognitively intact.	F0656		
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, resident and staff interviews, and record review, the facility failed to ensure adequate accident prevention for one (1) of five (5) residents reviewed for accident hazards (Resident #3). The facility failed to ensure the resident's ordered three-quarter length side rail was maintained in the raised position while the resident was in bed, resulting in the resident rolling out of bed and sustaining a fracture. Findings Include: Review of a statement on facility letterhead revealed that "Proper Name" Care Center did not have a specific policy pertaining to accident prevention. An observation conducted on 12/10/25 at 8:30 AM revealed Resident #3 in bed with three-quarter length side rails raised on both sides of the bed. Review of the Medication Review Report dated 1/13/25 revealed an order for three-quarter length side rails to be used as enablers to assist with turning and repositioning while in bed, with instructions to	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0689 SS = G	Continued from page 11 release and reposition every two hours and as needed. Review of an accident report dated 10/29/25 at 01:00 AM revealed that staff heard yelling from down the hall. Upon entering the room, staff observed Resident #3 lying under the bedside table beside the bed. The resident's right leg was wrapped in a blanket, skin tears were noted to both elbows, and the resident complained of right hip pain. The resident stated, "Yeah, I think it's broke," and further stated he "rolled out of bed during sleep." Review of Emergency Department records dated 10/29/25 revealed Resident #3 was diagnosed with a closed comminuted intertrochanteric fracture of the proximal end of the right femur. An interview with Resident #3 on 12/10/25 at 9:00 AM revealed he confirmed experiencing a fall in October when he rolled out of bed during the night because his side rail was not raised. He stated he uses the side rails to assist with turning and repositioning while in bed because he is an amputee. When asked why the side rail was not raised, he stated he did not know who had lowered it, but when he rolled over, it would have prevented him from falling in the floor if it had been up. A phone interview with Certified Nurse Assistant (CNA) #1 on 12/10/25 at 10:10 AM revealed she responded to the fall after hearing the resident yelling. She stated that upon entering the room, Resident #3 was lying on the floor on the left side of the bed, and the left side rail was not raised. An interview with the Director of Nursing on 12/10/25 at 9:11 AM revealed that, upon investigation of Resident #3's fall on 10/29/25, it was her understanding that the side rail was not in the raised position at the time of the fall. She stated the resident's bed was equipped with three-quarter length side rails on both sides, which were utilized to assist with turning and repositioning while in bed and should have been raised to prevent him from rolling out of the bed. She further confirmed that the side rail not being raised contributed to the resident's fall resulting in injury and fracture. An observation conducted on 12/10/25 at 2:37 PM with CNA #2 revealed the lever used to lower the left side rail was located at the end of the side rail near the foot of the bed. CNA #2 stated Resident #3 would not be physically able to reach the lever to lower the side rail. She further stated the resident does not attempt	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0689 SS = G	Continued from page 12 to get up without assistance and uses the side rails to assist with turning and repositioning since he is an amputee. Record review of the Admission Record revealed Resident #3 was admitted on 10/9/24 with diagnoses including acquired absence of the left leg above the knee and other reduced mobility. Record review of the Brief Interview for Mental Status (BIMS) dated 11/8/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure fluid intake was managed, tracked, and documented in accordance with a physician ordered fluid restriction for a resident receiving dialysis for one (1) of six (6) resident reviewed for fluid restrictions. Resident #87 Findings Include:	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0692 SS = D	Continued from page 13 Review of the facility policy titled “Encouraging and Restricting Fluids” revised 10/10 revealed under, “Purpose: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health.” The policy further revealed under, “Steps in the Procedure: … 5. Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid in MLs (milliliters).” Record review of Resident #87’s December 2025 Medication Administration Record (MAR) revealed an order dated 7/16/25, “Record fluid intake in 24 hours. 900 cc (cubic centimeter) fluid restriction – Breakfast 200, Lunch 200, Dinner 200, Medications 200, Snacks 100.” Review revealed there was no documentation of fluid intake amounts recorded, and the MAR was only initialed by the nurse. Record review of Resident #87’s December 2025 “Flowsheet” revealed there was no evidence that fluid intake was monitored or documented. Record review of Resident #87’s December 2025 “MAR” revealed an order dated 8/03/24, “Nepro/Carb Steady Oral Liquid (Nutritional Supplement) give 8 ounces by mouth two times a day for End Stage Renal Disease (ESRD).” Record review of Resident #87’s breakfast meal tray ticket dated 12/09/25 revealed under, “Notes: Add Nepro to all trays.” The tray ticket further revealed under, “Beverages: Fluid Restriction: 4 ounces (OZ) Apple juice – 1 cup, Water – 1 cup.” An observation on 12/09/25 at 8:06 AM revealed Resident #87 received her breakfast meal in her room which included two pieces of bacon, scrambled eggs, toast, 240 milliliters (ML) of water, and 120 ML of apple juice, totaling 360 ML of fluid at one meal, excluding the Nepro supplement. An interview with the Director of Nursing (DON) on 12/10/25 at 11:32 AM revealed fluid restrictions were to be tracked on the MAR and totaled at the end of each shift. The DON confirmed this had not been done for Resident #87 and stated the resident could be receiving too much fluid, which could contribute to fluid volume overload. She further confirmed there was inconsistency with the Nepro supplement and stated this would place the resident over her fluid restriction and should have been clarified. An interview with the Registered Dietitian (RD) on 12/10/25 at 11:52 AM revealed Resident #87 was	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0692 SS = D	Continued from page 14 receiving Nepro twice daily; however, she spoke with the dialysis RD in September, who suggested increasing the Nepro to three times daily. The RD confirmed she had not calculated the Nepro into the resident's daily fluid allowance. She further confirmed she was aware the resident's fluid intake was not being documented or totaled at the end of the shift but did not report this to the nursing department. She acknowledged this failure could cause the resident to develop fluid volume overload. Record review of the Admission Record revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 11/02/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #87 was cognitively intact.	F0692		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to ensure meals were served in accordance with a resident's physician-ordered nutritional requirements for one (1) of four (4) residents reviewed for dining. Resident #87 Findings Include: The facility provided a statement on letterhead that read, "(Proper name of the facility) does not have a specific policy on therapeutic diet." During an observation on 12/09/25 at 8:06 AM, Resident #87 was observed sitting up in her wheelchair in her room with her breakfast tray in front of her untouched.	F0808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0808 SS = D	Continued from page 15 The resident had 2 pieces of bacon, scrambled eggs, toast, water, and apple juice. Review of the meal ticket dated 12/09/25 revealed, “Supplements: Nepro – 1 carton” and under “Notes; Add Nepro to all trays.” The Nepro supplement was not on the meal tray. Resident #87 stated she only received it “sometimes.” An observation and interview with Licensed Practical Nurse (LPN) #1 on 12/09/25 at 8:12 AM confirmed Resident #87 did not receive the Nepro supplement as ordered on the meal ticket. LPN #1 stated the meal provided should match the meal ticket and acknowledged the resident would not receive the necessary nutrients if supplements were omitted. An interview with the Dietary Manager (DM) on 12/09/25 at 3:26 PM revealed she was made aware that Resident #87 did not receive Nepro with her breakfast meal. She stated it was the dietary drink aide’s responsibility to read the meal cards and provide the necessary supplements on the meal tray. She described the incident as a “human mistake” and acknowledged Resident #87 would not get the necessary nutrients. Record review of the “Admission Record” revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 11/02/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #87 was cognitively intact.	F0808		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0880 SS = D	Continued from page 16 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0880 SS = D	Continued from page 17 linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to clean and disinfect a multi-use glucometer according to the manufacturer's instructions and the required wet contact time for one (1) of two (2) glucometers observed. Resident #16 Findings Include: Review of the facility policy titled “Assure Prism Multi Blood Glucose Monitor System: Use, Cleaning and Controls Policy” undated, revealed under, “Cleaning and Disinfecting the Assure Prism Multi Blood Glucose Monitoring System: 1. Follow standard precautions and the manufacture’s disinfection procedures to clean and disinfect the meter.” On 12/10/25 at 8:15 AM, an observation of Licensed Practical Nurse (LPN) #3 revealed she completed a blood glucose check for Resident #16 and then cleaned the glucometer using Sani-cloth germicidal wipes by swiping over the front and back of the machine three times for a total of 30 seconds. LPN #3 explained this was how she had been trained to clean the glucometer and stated this was the method their facility policy instructed them to use. LPN #3 was not aware of the wet contact time required on the back of the Sani-cloth container. She acknowledged that if the machine was not cleaned appropriately, it could spread germs to other residents because the glucometer was used on multiple residents. Record review of the manufacturer’s instructions “Arkway Technical Brief Cleaning and Disinfecting the Assure Prism multi–Blood Glucose Monitoring System (BGMS)” revealed Super Sani-Cloth® Germicidal Disposable Wipe was listed for use in cleaning and disinfecting the meter. Further instruction revealed, “Meter surfaces must remain wet according to contact times listed in the wipe manufacturer’s instructions."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , 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
F0880 SS = D	Continued from page 18 Record review of the “Super Sani-cloth Germicidal Disposable Wipes” revealed, “unfold wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes.” An interview with the Director of Nursing (DON) on 12/10/25 at 10:48 AM revealed the staff recently attended training and were taught to swipe over the glucometer with Sani-cloth wipes three times on the front and back. The DON explained she was aware of the required wet contact time on the Sani-cloth wipes and confirmed that improper glucometer cleaning practices could spread infection throughout the building. Record review revealed the facility admitted Resident #16 on 6/07/24 with medical diagnoses including Unspecified Sequalae of Cerebral Infarction and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 12, indicating Resident #16 was moderately cognitively impaired.	F0880		