STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23093	(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
M0000	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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA cited M500, M640, M650, and M1570. The census at the time of the survey was 103 and the facility is licensed for 120 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be	M0500		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0500	Continued from page 1 limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the	M0500		

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M0500	Continued from page 2 emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M0500		

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M0500	Continued from page 3 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide privacy for a resident during care (Resident #16) and failed to ensure a resident's code status was accurate and consistent with the resident's wishes (Resident # 10) for two (2) of 23 sampled residents. Resident #10 and #16 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". Review of the facility policy titled "Resident Rights" revised 12/16 revealed under, "Policy Statement: Employees shall treat all residents with kindness, respect, and dignity." Also revealed under, "Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These include the resident's right to: ... t. privacy and confidentiality;" 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	M0500		

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M0500	Continued from page 4 privacy during assistance with personal care and during treatment procedures." Resident #10 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)" 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,	M0500		

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M0500	Continued from page 5 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. Resident #16 On 12/10/2025 at 8:15 AM, during an observation of medication pass with Licensed Practical Nurse (LPN) #3, 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. During an interview with LPN #3 on 12/10/25 at 8:32 AM, she confirmed the 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. On 12/10/25 at 10:48 AM, an interview with the DON revealed that residents were expected to be provided privacy during care and confirmed this was a dignity	M0500		

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M0500	Continued from page 6 concern. 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 MDS with an ARD of 9/05/25 revealed under section C, a BIMS summary score of 12, indicating Resident #16 was moderately cognitively impaired.	M0500		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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 release and reposition every two hours and as needed. Review of an accident report dated 10/29/25 at 01:00 AM	M0640		

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M0640	Continued from page 7 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 to get up without assistance and uses the side rails to assist with turning and repositioning since he is an amputee.	M0640		

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M0640	Continued from page 8 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.	M0640		
M0650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure fluid intake was managed, tracked, and documented for a resident with a physician-ordered fluid restriction receiving dialysis for one (1) of six (6) resident reviewed for fluid restrictions. Resident #87 Findings Include: 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 ounce by	M0650		

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M0650	Continued from page 9 mouth two times a day for ESRD (End Stage Renal Disease)." 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 OZ. (ounces) 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 ML (milliliters) of water, and 120 ML (milliliters) of apple juice, totaling 360 milliliters of fluid at one meal, excluding the Nepro supplement. During an interview with the Director of Nursing (DON) on 12/10/25 at 11:32 AM, she revealed fluid restrictions were to be tracked on the medication administration record (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. During an interview with the Registered Dietitian (RD) on 12/10/25 at 11:52 AM, she revealed Resident #87 was 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.	M0650		
M1570	48.58.1 Infection Control	M1570		

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M1570	Continued from page 10 The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 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.” An observation of Licensed Practical Nurse (LPN) #3 on 12/10/25 at 8:15 AM, revealed she completed a blood glucose check for Resident #16 and then cleaned the glucometer using Sani-cloth germicidal wipes by swiping	M1570		

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TUPELO COMMUNITY CARE CENTER	1901 BRIAR RIDGE ROAD , TUPELO, Mississippi, 38804

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M1570	Continued from page 11 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." 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." During an interview with the Director of Nursing (DON) on 12/10/25 at 10:48 AM, she 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.	M1570		