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 01/14/2026

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 Annual Recertification survey and six (6) Complaint Investigations (CI) MS #2700059, CI MS #2693699, CI MS #2704745, CI MS #2688890, CI MS #2698633, CI MS #2699004 and one (1) Facility Reported Incident (FRI) MS #2715132 at the facility from 1/11/26 through 1/14/26. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F600, F628, F656, F657, F677, F689, F690, F757, and F880. The SA identified non-compliance and cited F600 regarding Abuse for the (FRI) MS # 2715132. The SA investigated CI MS #2700059, CI MS #2693699, and CI MS #2704745, CI MS #2688890, CI MS #2698633, and CI MS #2699004 with no deficiencies cited. The census at the time of the survey was 106 and the facility was licensed for 120 beds.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility	F0600		

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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F0600 SS = D	Continued from page 1 failed to ensure a resident's right to be free from sexual abuse for one (1) of 32 initial pool residents. Resident #14 Findings Include: Review of the facility policy titled “Abuse Policy,” unrevised, revealed under Policy Statement: “It is the policy of the center to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of resident/patient property...” Record review revealed the facility reported an allegation of abuse to the State Agency on 1/10/26 at 11:30 AM after a staff member witnessed Resident #56 touching Resident #14 inappropriately. The residents were immediately separated and Resident #56 denied the allegation, and an investigation was initiated. An observation of Resident #56 on 1/11/26 at 3:45 PM revealed he was sitting in his wheelchair outside his room doorway with a Certified Nurse Aide (CNA) sitting nearby. Resident #56 stated he “had behaviors” and that staff were watching him. An interview with Licensed Practical Nurse (LPN) #6 on 1/12/26 at 9:16 AM revealed Resident #56 touched Resident #14’s breast over the weekend and had been placed on one-to-one supervision for observation. Record review of Resident #56’s “Progress Notes” dated 1/10/26 revealed, “Staff reported to this nurse that resident touched another resident breast. Resident stated that he did it because he loves her.” Record review of Resident #56’s “Progress Notes” dated 1/10/26 revealed the Social Worker spoke with Resident #56 regarding the allegations. The entry documented that Resident #56 did not deny the touching and told the Social Worker, “That’s what a man does when he is in love.” An observation of Resident #14 on 1/12/26 at 10:34 AM revealed she was ambulatory and standing at the entrance of another resident’s room. She was easily directed to her room and Resident #14 displayed a flat affect and responded to simple questions; however, her responses were inconsistent and suggested she did not fully understand or recall what was being asked. When questioned about the touching incident, she stated she did not remember and could not recall any part of the event.	F0600		

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F0600 SS = D	Continued from page 2 An interview with Resident #56 on 1/13/26 at 8:41 AM revealed that on 1/10/26 he was sitting at the dining table talking with Resident #14. He stated, "I accidentally touched her on the breast." He reported Resident #14 told him, "I love you," and stated he had been talking with her for a day or two prior to the incident and was attracted to her. He stated staff moved him back to his dining table afterward and began "watching" him. He acknowledged he had been attracted to other female residents before but had not touched them. An interview with Social Services (SS) on 1/13/26 at 8:53 AM revealed she spoke with Resident #56 on the date of the incident. She stated Resident #56 told her, "That's what men do when they are in love." She stated he was cognitive and was educated about respecting other residents' personal space. SS reported Resident #14 was unable to recall the incident. An interview with the Director of Nursing on 1/13/26 at 2:04 PM revealed the incident occurred in the dining area and was witnessed by a CNA. She stated the residents were separated and Resident #56 was placed on one-to-one staff observation until psychiatric services could evaluate him. An interview with CNA #4 on 1/13/26 at 2:18 PM revealed she was walking toward the dining room when she noticed a dietary employee observing something occurring between Resident #56 and Resident #14. CNA #4 stated she entered the dining room and observed Resident #56 touching Resident #14's breast on the outside of her shirt while both residents sat at a dining table. CNA #4 reported she told him she was going to report the incident, and he replied, "I don't care." She reported the incident to the nurse. An interview with Dietary Staff #1 on 1/14/26 at 11:19 AM revealed she saw both residents sitting together in the dining room and observed Resident #56 stroking Resident #14's face and rubbing her hair. She stated there were no staff present in the dining room at that time. She stated CNA #4 noticed the interaction and entered the room to check. Dietary Staff #1 stated she returned to her duties and did not personally witness the breast touching. Record review of Resident #56's Psychiatric Telemedicine Visit dated 1/10/26 revealed under Subjective: "Earlier today, staff reported the patient inappropriately touched a female resident by rubbing her, which he acknowledges doing 'to see her reaction,' though he expected 'nothing' from it. He stated he	F0600		

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F0600 SS = D	Continued from page 3 likes the resident." During an interview on 1/14/26 at 3:28 PM with the Director of Nursing, she stated she was aware that all residents have the right to be free from abuse and that the facility was responsible for protecting residents from such conduct. Record review of the "Admission Record" revealed the facility admitted Resident #14 on 12/26/25 with medical diagnoses including Unspecified Dementia, Unspecified Severity, with Mood Disturbance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating Resident #14 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #56 on 1/27/24 with medical diagnoses including Epilepsy, Anxiety Disorder, and Unspecified Mood Disorder. Record review of the MDS with an ARD of 1/5/26 revealed under section C, a BIMS score of 15, indicating Resident #56 was cognitively intact.	F0600		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F0628		

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F0628 SS = D	Continued from page 4 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F0628		

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F0628 SS = D	Continued from page 5 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must	F0628		

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F0628 SS = D	Continued from page 6 update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not	F0628		

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F0628 SS = D	Continued from page 7 limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the State Long-Term Care Ombudsman of a resident's transfer to the hospital, which did not ensure compliance with required notification procedures for resident transfers for one (1) of four (4) hospitalizations reviewed. Resident #46 Findings Include:Record review of facility policy titled, "Transfer and Discharge" dated 11/1/16, revealed "4. Before (Proper name of facility removed) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand; and will also notify the State Long-Term Care Ombudsman..." Record review of Resident #46's "Order Details" revealed an order dated 11/21/25 to "send to (Proper name of hospital removed) ER (Emergency Room) for AMS (Altered Mental Status)". Record review of the "Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman" for the month of November 2025, revealed Resident #46 was not listed for his 11/21/25 transfer. During an interview on 1/13/25 at 4:05 PM, the Administrator revealed that she was responsible for the completion and submission of the "Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman". She acknowledged that this log provided the Ombudsman with the information on residents transferred to the hospital. She confirmed she failed to place Resident #46's name on the November log for his 11/21/25 admission. Record review of Resident #46's "Admission Record" revealed he was admitted by the facility on 10/24/23 with diagnoses of Gastro-esophageal Reflux Disease and Chronic Obstructive Pulmonary	F0628		

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F0628 SS = D	Continued from page 8 Disease. Record review of Resident #46's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was intact cognitively.	F0628		
F0656 SS = D	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 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	F0656		

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F0656 SS = D	Continued from page 9 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, staff interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan for two (2) of 28 residents sampled. (Resident #39 and Resident #58) Findings include: Review of facility policy titled “Care Plans” with effective date: October 2021, revealed, “Policy…Care plans are developed by the interdisciplinary team and revied as needed according to resident and patient status or change.” Record review of Resident #39’s “Medication Administration Record” (MAR) for January 2026, revealed Resident #39 was currently on an anticoagulant Eliquis five (5) milligram (mg) tablet by mouth (PO) two times a day as of 10/15/25. There was no monitoring for signs/symptoms of bleeding. Record review of Resident #39’s Care Plan “Risk for complications related to anticoagulant…” with review date 10/23/2025, revealed, “…Observe for sign and symptoms (S/S) of bleeding example (i.e.) tarry stools, blood in urine, bruising, petechiae…” During an interview on 1/12/2026 at 3:41 PM, the Director of Nursing (DON) confirmed there is not an order to monitor for bleeding every (q) shift. She stated her expectations were that any resident on an anticoagulant should have an order on the MAR to monitor for s/s of bleeding. She verbalized the resident was at risk for bleeding because she is taking an anticoagulant. Record review of the Admission Record revealed Resident #39 was admitted to the facility on 10/14/2025 with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Unspecified Systolic (Congestive) Heart Failure, and Paroxysmal Atrial Fibrillation. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2025	F0656		

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F0656 SS = D	Continued from page 10 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident # 58 Record review of Resident #58's Care Plan Report revealed an ADL self-care performance deficit related to other failure to thrive including, "provide all the effort with the following tasks as this resident is dependent: oral hygiene, toileting hygiene, shower/bathe self...". On 1/11/2026 at 4:00 PM, during initial rounds, Resident #58 stated she had received her baths; however, she stated she had not had her hair washed in approximately two weeks and stated she would like her hair washed. On 1/12/2026 at 4:33 PM, during an interview and observation Registered Nurse (RN) #1 was interviewed at the resident's bedside and confirmed the resident's hair appeared unwashed. During an interview on 1/13/2026 at 1:30 PM, the MDS Coordinator confirmed that hair washing is included as part of the resident's ADL care plan. When asked to identify the frequency or specific days the resident was scheduled to have her hair washed, the MDS Coordinator stated it was to occur on the resident's bath or shower days. The MDS Coordinator further stated the purpose of the care plan is to guide staff how to best provide care for the residents. Record review revealed Resident #58 was admitted to the facility on 7/30/2025 with diagnoses that included Cognitive Communication Deficit. Record review of the quarterly MDS with an ARD of 10/20/2025 revealed a BIMS score of 07, indicating mildly impaired cognition.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657		

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(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
F0657 SS = D	Continued from page 11 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to revise the comprehensive care plan, following a fall, on one (1) of 28 residents sampled. (Resident #83) Findings include: Review of facility policy titled “Care Plans” with effective date: October 2021, revealed, “Policy…Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change...” During observation and interview on 1/11/2026 at 3:43 PM, Resident #83 was lying in bed. She was observed to have old, facial bruising. Resident #83 stated she had a fall in her room, but it was a long time ago. She stated, "It's almost healed now." Observed that her bed was not in low position during observation. Record review of "Post Fall Review" with effective date 1/1/2026, revealed, "...Date and time of fall: 12/31/2025 21:06 (9:06 PM)...Interventions/recommendations post	F0657		

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F0657 SS = D	Continued from page 12 fall...Recommendations/Interventions...Bed in low position...Care Plan/Kardex updated with new interventions: No..." Record review of Resident #83's "Risk for Falls" care plan with revision date 10/3/2025, revealed, no interventions listed for resident's bed to be in low position. During an interview on 1/13/2026 at 3:09 PM, the Director of Nursing (DON) confirmed that the intervention for bed in low position was not added to the care plan or to the Kardex. She stated, "it seems like we did something different with her mattress". She stated that all the beds were supposed to be left in low position. She further stated that the care plan was to be used as a guide on how to provide care for the residents and that the intervention was intended to lessen the possibility of injury should she fall again. Record review of the Admission Record revealed Resident #83 was admitted to the facility on 10/1/2025 with medical diagnoses that included Peripheral Vascular Disease, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 02, indicating the resident had severely impaired cognition.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to ensure a resident who required assistance received activities of daily living (ADL) care, including grooming and personal hygiene services such as hair washing, in accordance with the resident's assessed needs, for one (1) of 29 residents. (Resident #58) Findings Include: Review of facility policy titled "Activities of Daily Living (ADLs)", with an effective date of August 2021, revealed the facility policy is to	F0677		

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F0677 SS = D	Continued from page 13 ensure activities of daily living are provided in accordance with accepted standards of practice, the resident's care plan, and reasonable accommodation of the resident's choices and preferences. The policy further identified hygiene activities of daily living to include bathing, dressing, grooming, and oral care. During an interview on 1/11/2026 at 4:00 PM, Resident #58 stated she has received her baths but hasn't had her hair washed in approximately two weeks; she stated she would like her hair washed. During an interview and observation on 1/12/2026 at 4:33 PM, Registered Nurse (RN) #1 was interviewed at the resident's bedside and confirmed the resident's hair appeared unwashed. During an interview on 1/14/2026 at 9:36 AM, Certified Nursing Assistant (CNA) #5 stated she was not familiar with the resident and the past couple weeks she did not wash her hair because she did not want to cause her pain. CNA #5 further stated that now that she knows the resident, she will wash the resident's hair on Mondays, Wednesdays, and Fridays, which are the resident's scheduled shower days. On 1/14/26 at 10:00 AM, the Director of Nursing (DON) stated that the expectations are for the resident's hair to be washed by the CNAs on scheduled shower days. Record review of the Admission Record revealed Resident #58 was admitted to the facility on 7/30/2025 with diagnoses that included Cognitive Communication Deficit. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/2025 revealed a Brief Interview for Mental Status (BIMS) score of 07, indicating severly impaired cognition.	F0677		
F0689 SS = D	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 observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure adequate supervision and monitoring	F0689		

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F0689 SS = D	Continued from page 14 for one (1) of 28 residents reviewed following expressions of suicidal ideation, despite receiving post-emergency room recommendations for psychiatric follow-up. (Resident #8) Findings include: Review of facility policy titled, “Behavioral Health Services” with no date revealed, “Each…resident must receive…the necessary behavioral health care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being…” Interview with Resident #8 on 01/11/26 at 3:45 PM the resident stated that she had been to the Emergency Room (ER) recently and that she wanted to see a psychiatrist and had not seen one yet. Review of the ER records revealed Resident #8 presented to ER with mood instability and insomnia on 01/10/26. Documentation indicated the resident experienced crying spells and moodiness, with fleeting thoughts of self-harm without plan, intent, or access to means. The resident declined psychiatric admission and stated inpatient care was not necessary. She expressed a desire for outpatient psychiatric follow-up with psychiatrist who visits the facility. The physician documented, "Patient appears stable; I do not feel the patient is a risk to herself as she has not endorsed any suicidal ideation at this time. She is in assisted living facility and can receive care from her psychiatrist there for medication adjustment..." Documentation further revealed, "...Patient states she has been feeling depressed and anxious and wanted to see a psychiatrist, but the (facility name removed) nurses ‘wouldn't listen to her’ so she made a comment about being suicidal. Upon admission to the ER, patient stated she was not actively suicidal and never had a plan..." During an interview on 1/13/2026 at 11:22 AM, Licensed Practical Nurse (LPN) #5 stated Resident #8 returned from the ER at approximately 12:19 AM on 1/11/2026 with no new orders. She stated she confirmed with Emergency Medical Services (EMS) that the resident had not received medication while at the ER; therefore, she administered the resident’s nighttime medications and assisted her to bed. She stated the ER did not provide a referral or follow-up orders. During an interview on 1/13/2026 at 11:13 AM, Social Services stated she spoke with Resident #8; however, no documentation was present to support that interaction.	F0689		

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F0689 SS = D	Continued from page 15 She further stated she made a referral on Monday, 1/12/2026, with (Proper Name) Health Services. She stated (Proper Name) Health Services provides weekly visits and that the Master Social Worker (MSW) was in the facility that day and scheduled to see the resident. She stated this behavior was new for Resident #8 and she completed a PHQ9 assessment (questionnaire to screen for depression) upon admission and again in November 2025, and neither assessment indicated concerns. She also stated the resident had experienced multiple room changes due to incompatibility with roommates. Review of the ER document titled "Iris Telepsychiatry Consult Note" dated 1/10/2026, revealed the following recommendations: “Medication recommendations: Review and adjust the current antidepressant regimen by facility psychiatric provider. Consider initiation or titration of a non-benzodiazepine anxiolytic appropriate for geriatric patients. Consider sleep-focused pharmacologic intervention (e.g., low-dose trazodone or mirtazapine, if clinically appropriate and not contraindicated). Avoid benzodiazepines if possible given age-related risks unless clearly indicated and closely monitored. 2. Non-Medication/therapeutic recommendations: Urgent psychiatric follow-up at assisted living facility; recommend expedited evaluation rather than routine monthly rounding. Facility staff monitor mood, anxiety, and sleep patterns closely. Encourage daughter's involvement in advocacy and care coordination. Environmental modifications at facility to reduce anxiety triggers (noise reduction, door-open accommodations due to claustrophobia). During an interview on 1/13/2026 at 3:03 PM, the Director of Nursing (DON) confirmed resident was sent to ER as the facility's intervention when the resident stated that she wanted to harm herself. She stated, "Since the hospital sent her back to us, we look at that as she's safe to come back to the facility...like an ‘all clear’ to us. That is why we did not put any additional interventions or monitoring into place." Record review of the Admission Record revealed Resident #8 was admitted to the facility on 8/19/2025 with medical diagnoses that included Urinary Tract Infection, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Bipolar Disorder, current episode hypomanic, Other Bipolar Disorder, Depression, and Anxiety. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2025	F0689		

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F0689 SS = D	Continued from page 16 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure catheter care was performed correctly for one (1) of six (6) residents with an indwelling urinary catheter. Resident #70. Findings Include:	F0690		

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F0690 SS = D	Continued from page 17 Record review of the facility's "Peri Care Audit Tool" (undated) revealed, "11. If Foley catheter present, must wash catheter tube first before starting the peri care. Washes from the meatus up the tube about 6 inches X2 (times two) with changing position of cloth." An observation of Resident #70's catheter care with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:40 PM revealed she prepared to provide catheter care and filled one pan with clean water. CNA #4 wet a washcloth and applied Dynacare shampoo and body wash directly to the cloth. She washed the resident's groin area first, then washed the shaft of the penis, and lastly washed the urinary meatus followed by the catheter. She did not rinse the washcloth with soap between cleaning the different areas of the groin area. An interview with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:54 PM confirmed that she did not use the correct catheter-cleaning sequence during Resident #70's care and acknowledged she did not rinse the soap. CNA #4 explained she was "in a hurry and messed up." She acknowledged this could cause the resident to get a urinary tract infection. An interview with the Director of Nursing on 1/12/26 at 4:02 PM confirmed improper catheter-care sequence could cause Resident #70 an infection and that not rinsing soap could cause skin irritation. Record review of the "Admission Record" revealed the facility admitted Resident #70 on 11/3/25 with medical diagnoses including Obstructive and Reflux Uropathy and Urinary Tract Infection. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #70 was moderately cognitively impaired. Section H indicated an indwelling catheter was marked.	F0690		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F0757		

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F0757 SS = D	Continued from page 18 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, facility record review, and facility policy review, the facility failed to ensure ongoing monitoring for adverse effects of a medication for one (1) of five (5) residents reviewed for medication review. (Resident #39). Findings include: Review of document on facility letterhead, dated 1/14/26, with the Administrator's signature, revealed, "Standards of Practice…The expectation set forth by (facility proper name removed) management is that nurses comply with current standards of practice for residents needing anticoagulant monitoring." Record review of Resident #39's medical record revealed the resident was prescribed Eliquis five (5) milligram (mg) tablet by mouth (PO) two times a day on 10/15/2025; however, the record lacked evidence that nursing staff monitored for signs and symptoms (s/s) of bleeding. On 1/12/2026 at 3:41 PM, during an interview the Director of Nursing (DON) confirmed there was no order to monitor every (q) shift for bleeding. She stated her expectation was that any resident receiving an	F0757		

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F0757 SS = D	Continued from page 19 anticoagulant should have an order on the Medication Administration Record (MAR) to monitor for signs and symptoms of bleeding. She further stated the resident was at risk for bleeding due to anticoagulant use. Record review of the Admission Record revealed Resident #39 was admitted to the facility on 10/14/2025 with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Unspecified Systolic (Congestive) Heart Failure, and Paroxysmal Atrial Fibrillation. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F0757		
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: §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	F0880		

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F0880 SS = D	Continued from page 20 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 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 observation, staff interview, facility policy review, the facility failed to ensure infection prevention and control practices were consistently implemented in accordance with accepted standards of practice. Specifically, the facility failed to maintain oxygen equipment by not dating the oxygen tubing and oxygen humidifier water bottles for Residents #37 and	F0880		

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F0880 SS = D	Continued from page 21 #93 and failed to ensure staff followed Enhanced Barrier Precautions (EBP) by not wearing a gown during Foley catheter care for a resident requiring EBP (Resident #70). These failures affected three (3) of twenty nine sampled residents. Findings Include: Record review of the facility policy titled “Oxygen Guideline” with an effective date of 1/1/2022 revealed, “Medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided in accordance with a health care provider’s order and in accordance with acceptable standards of practice.” Review of the “Infection Control Guide” dated 2025 revealed under, “System of Isolation for Infection Control: Enhanced Barrier Precautions should be considered when: Any resident with any: … Wound and/or indwelling medical devices (e.g., central lines, urinary catheter”. It also revealed under “Required: Gloves and gown don prior to the high-contact care activity.” Resident #37 An observation on 1/11/26 at 3:45 PM revealed that Resident #37's oxygen tubing and the humidifier water bottle were not dated. A subsequent observation on 1/12/26 at 10:20 AM revealed that the oxygen tubing and humidifier water bottle remained undated. A record review of Resident #37's "Admission Record" revealed the facility admitted the resident on 7/6/25 with diagnoses that included Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Section O revealed that the Resident receives Oxygen therapy. Resident #93	F0880		

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F0880 SS = D	Continued from page 22 An observation on 1/11/26 at 4:00 PM revealed that Resident #93 was receiving oxygen via an oxygen concentrator. The oxygen tubing and oxygen humidifier water bottle were not dated. An observation on 1/12/26 at 10:20 AM revealed the oxygen tubing and the water bottle remained undated. A record review of Resident #93's "Admission Record" revealed the facility admitted the resident on 11/1/25 with diagnoses that included Chronic Obstructive Pulmonary Disease. A record review of Resident #93's MDS with an ARD of 11/7/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Section O revealed that the Resident receives Oxygen therapy. During an interview and observation on 1/12/26 at 3:05 PM, Licensed Practical Nurse (LPN) #4 revealed that the oxygen tubing and water bottles are always to be dated when they are changed, because otherwise we don't know how long the resident has been using the same tubing. She confirmed that the oxygen tubing and water bottle for Residents #37 and #93 were not dated. LPN #4 stated, “By not keeping track of when the oxygen tubing and water bottle are changed out, it could set the residents up for a respiratory infection.” During an interview on 1/12/26 4:28 PM, the Director of Nurses (DON) revealed the facility previously documented when oxygen tubing and humidifier water bottles were changed; however, we were notified that our policy had changed, and we removed the documentation from our electronic system. The DON stated, “oxygen tubing is changed only when visibly soiled and humidifier water bottles are changed only when empty.” She confirmed that the facility does not date oxygen tubing or water bottles and acknowledged that there is no method to determine when the equipment was last changed. During an interview on 1/12/2026 at 4:44 PM, the Director of Clinical Care Coordination revealed, "I think we should be changing them out weekly, but they have changed the policy now to where the facility only changes the tubing when they notice it is dirty and the	F0880		

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 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	**2273 SOUTH EASON BOULEVARD , TUPELO, Mississippi, 38804**

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F0880 SS = D	Continued from page 23 bottles when they are empty." She confirmed there was no way to determine when the oxygen tubing or the humidifier water bottle was last changed due to the absence of dating and acknowledged that this practice could place residents at risk of infection. Resident #70 During an observation of Resident #70's catheter care with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:40 PM, she performed catheter care without applying a gown as required for EBP. During an interview with CNA #4 on 1/12/26 at 3:54 PM, she stated she had the gown ready for use during catheter care but forgot to apply it. She stated the purpose of wearing the gown was to protect the resident from infections. During an interview with the Director of Nursing on 1/12/26 at 4:02 PM, she stated her expectation was for staff to follow Enhanced Barrier Precautions to reduce infection risk. Record review of the "Admission Record" revealed the facility admitted Resident #70 on 11/3/25 with medical diagnoses including Obstructive and Reflux Uropathy and Urinary Tract Infection. Record review of the MDS with an ARD of 11/10/25 revealed under section C, a BIMS summary score of 10, which indicated Resident #70 was moderately cognitively impaired. Section H indicated an indwelling catheter was marked.	F0880		