STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey and complaint investigations (CI MS #18009, CI MS #18112, CI MS #18115, CI MS #18160, CI MS #18230) survey at the facility from 12/06/2021 to 12/09/2021. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550 Resident Rights, F584 Safe/Clean/Homelike Environment, F623 Notice Requirements Before Transfer, F625 Notice of Bed Hold, F645 Preadmission Screening and Resident Review (PASARR), F656 Develop/Implement Comprehensive Care Plans, F677 Activities of Daily Living (ADL) Care, F880 Infection Prevention and Control and F924 Handrails. During the survey, CI MS #18230 resident not groomed was substantiated and F677 was cited in the annual survey. CI MS #18112 resident left wet, body odor CI MS #18009 related to no pressure sore precautions, Resident Representative not notified, CI MS #18160 fall safety, treated with dignity, Resident Representative not notified, CI MS #18115 Resident safety, were not substantiated. The facility was licensed for 120 beds and had a census of 98 at the time of the survey. The SA re-entered the facility on 12/20/21 - 12/21/21 for complaint investigations CI MS #18369 and CI MS #18374. CI MS #18374 was substantiated for failure to provide Activities of Daily Living. CI MS #18369 was not substantiated for feeding assistance and Resident Representative notification.	F 000		

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

Electronically Signed | 01/07/2022

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F 550 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. §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	F 550		2/11/22

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview, record review and facility policy review, the facility failed to provide privacy during care as evidenced by no window covering for one (1) of twenty (20) residents observed. Resident #76. Findings include: Review of facility policy titled, "Resident Bill of Rights", dated 11/2017, revealed, "Facility residents shall have the right to: personal privacy and confidentiality in his or her accommodations, personal and medical treatments and records, written and telephone communications, personal care, visits, and meetings of family and resident groups." An interview on 12/9/2021 at 11:47 AM, with Director of Nurses (DON), revealed the facility did not have a specific policy on privacy or dignity. She revealed the "Resident Bill of Rights" was used for dignity and privacy concerns. During an observation and interview on 12/7/2021 at 10:00 AM, Resident #76 revealed his window blinds had been broken for two to three months and he told the staff, but the window blinds were not replaced. Resident #76 stated that at times, he had been incontinent and had to be changed by the facility staff. He stated he felt exposed and uncomfortable being changed with no window covering. He stated he did not know if anyone was outside of his window, but if anyone was there, he was exposed to them. An observation	F 550	This Plan of Correction is submitted as required under Federal and State regulation and statuses applicable to long term care providers. This Plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. 1. Maintenance Director replaced blinds to the room of resident #76 on 12/8/2021. 2. All residents residing in the facility have the potential to be affected. 3. On 12/9/2021, a room audit of all rooms was conducted by the Maintenance Director and completed 12/10/2021 to ensure blinds not in disrepair, with no further negative findings. On 12/10/2021, the Administrator in-serviced the Maintenance Director and Maintenance Director Assistant regarding Resident Rights, Dignity, and Respect. On 12/15/2021, the Administrator initiated education with staff regarding Resident Rights, Dignity and Respect, and	

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F 550	Continued From page 3 revealed Resident #76's window blinds were broken and unable to close to cover the window for privacy. An interview on 12/7/2021 at 4:30 PM, with Resident #76 revealed his broken blinds were removed. Resident revealed he hoped the blinds would be replaced before dark so he would not feel that he was being looked at through the uncovered window. An interview with Resident #76 on 12/8/2021 at 8:45 AM, revealed the blinds had not been replaced and he slept without any window covering. He revealed he did not have to be changed by the facility staff through the night, but he used the urinal and got dressed and he felt uncomfortable with no window covering. An interview on 12/8/2021 at 4:55 PM, with the Administrator revealed each resident should be treated with dignity and offered privacy. She revealed that resident care being performed next to an uncovered window did not protect Resident #76's dignity and privacy. The Administrator confirmed that the facility failed to protect the resident's dignity and privacy by not providing a functioning window covering. An interview on 12/9/2021 at 9:00 AM, with Certified Nurse Assistant (CNA) #3, revealed that Resident #76's blinds had been broken and the window was unable to be covered for privacy and this had been reported. CNA #3 revealed she performed care and changed the resident with the broken blinds. She stated she "tries her best to protect his privacy", but it was not completely possible. She confirmed that Resident #76 was at risk of being exposed when	F 550	appropriate reporting of maintenance concerns. Beginning the week of 1/05/2022, the department managers will conduct room inspection audit (blinds, base boards and furniture) three times a week for two weeks,and then weekly for four weeks. On 1/7/2022, the room inspection audits will be reviewed weekly by the Administrator and Maintenance to ensure any negative findings are addressed and corrective action completed. 4. Beginning the week of 01/10/2022, the Administrator conduct resident room rounds weekly for four weeks to ensure corrective measures have been completed and sustained. Findings will be corrected and brought to the monthly Quality Assurance Performance Improvement Committee 01/11/2022 monthly for two months.	

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F 550	Continued From page 4 the window was uncovered. An interview on 12/9/2021 at 9:05 AM, with Licensed Practical Nurse (LPN) #2, revealed Resident #76's window was uncovered due to the blinds being broken and unable to close or open properly. She revealed the resident was continent most of the time, but he had occasional accidents, especially when he had diarrhea, and required being changed by staff. LPN #2 confirmed that doing resident care in front of an uncovered window was not protecting the resident's dignity and privacy. Record review of Resident #76's Face Sheet revealed the resident was admitted to the facility on 11/5/2020. Record review revealed the resident with diagnoses of Obstructive Sleep Apnea, Hypertension, Anxiety, Schizophrenia, Bipolar Disorder, and acquired absence of left and right leg below knees. Record review of Minimum Data Set (MDS) dated 10/21/2021, Section C, Cognitive, revealed Resident #76 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		2/11/22

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F 584	Continued From page 5 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and facility policy review, the facility failed to maintain a homelike environment as evidenced by dirty floors, gouged walls, and nonfunctional window blinds for three (3) of four (4) hallways.	F 584	1. On 12/7/2021, the Maintenance Director replaced both of the over-bed tables for room C2A and D5C and disposed of damaged tables. On 12/7/2021, the nightstand in room C9	

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F 584	Continued From page 6 Findings include: Review of the facility policy titled," Housekeeping Cleaning Procedures/Hallway Cleaning" revealed it is the responsibility of the housekeeping staff to: #3 dust mop floors, #4 Autoscrub floors w/red pads as needed, #5 Burnish floors after auto scrubbing, #6 Use spray buff where needed to repair/enhance gloss level, and #7 Spot clean hallway walls with BLUE microfiber cloth. An observation, on 12/6/21 at 11:55 AM, revealed the overbed table in Room C2A and D5C had torn sharp edges that are peeled up and the bedside table in Room C 9 had edges that were rough and partially covered with a torn white tape-like substance. An interview, on 12/6/21 at 12:00 PM, with Resident #80 revealed that she had not had any injury due to the rough sharp edges on the overbed table, but that the staff was aware it was damaged. An observation on 12/7/21 at 8:15 AM, revealed Resident #76's bed positioned in front of the window. The window blinds were pulled up and tangled. There were no curtains on the window. The wall behind the resident's bed had two (2) areas that were gouged through the sheet rock and a pile of tan and brownish colored powdery substance was present on the floor under the gouged-out areas in the wall. The wall behind the A bed area also had deep gouges in the sheet rock. An interview, on 12/07/21 at 8:16 AM with Resident #76 revealed his blinds had been pulled	F 584	with torn edges was removed and replaced. On 12/8/2021, Maintenance Director replaced the blinds to the room of resident #76. Additionally, on 12/9/2021, the Maintenance Director initiated repairs to the sheet rock (areas filled with sheet rock mud, allowed to dry and area sanded) and completed repairs on 12/15/2021. On 12/8/2021, corrective actions was taken by the housekeeper who cleaned brownish material from the wall on hall D. Corrective action was verified by the Administrator on 12/8/2021. On 12/15/2021, the base boards in D14 were replaced by the Maintenance Director and gouged area to wall in D14 repaired. On 12/08/21, housekeeping services swept the room and removed all powdery substances on the floor. On 12/15/2021, the housekeeping services conducted deep cleaning to room D14. On 12/14/2021, the Maintenance Director painted the door to room C2. Additionally, wall gouges to rooms C2 and C9 were repaired on 12/15/2021. 2. All residents residing in the facility have the potential to be affected. 3. On 12/8/2021, the Administrator in-serviced the housekeeper assigned to D hall regarding cleaning of common areas and surfaces to include hand rails and walls.	

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F 584	Continued From page 7 up and tangled like that for quite a while. He stated that he had mentioned it to the staff. An observation, on 12/7/21 at 8:35 AM, revealed Room C2A room door was painted with a thin coat of white paint that was scratched and marred over the entire door. An observation of Room D14A revealed the wall behind the bed was scratched and gouged in several places. The base boards are pulled away from the wall and laying loose on the floor with a whitish powdery substance on the floor behind the headboard. An observation in the D hallway on 12/7/21 at 12:20 PM, revealed dry brownish material that had run down the wall between Room D 11 and D 13. The housekeeper was observed cleaning the handrails over this area and did not clean the wall. An observation of the area between Room D11 and D13 on 12/8/21 at 9:00 AM, revealed the brownish material remained on the wall. An interview, on 12/8/21 at 9:15 AM, with Housekeeping Staff #2, confirmed the brownish material on the wall in the hall between Room D11 and D13. She stated that she guessed she just overlooked it when she was cleaning. She stated that it does not look nice, and she should have seen it. She stated that the floors need some work too. An interview on 12/8/21 at 9:05 AM, with the Administrator (ADM), confirmed she was aware the blinds in Resident #76's room needed to be replaced. She confirmed that the resident should have blinds or curtains to provide privacy. The ADM confirmed that the wall behind the beds in	F 584	On 12/10/2021, the Administrator in-serviced the Maintenance Director, Maintenance Assistant and Housekeeping Staff regarding Resident Rights, Privacy, Dignity and Respect, Routine preventative maintenance, and room cleaning/detailing work. On 12/10/2021, the Administrator initiated education to housekeeping staff regarding cleaning resident rooms and deep cleaning schedules. Beginning on 12/9/2021, Resident room audit was conducted by the Maintenance Director and completed on 12/10/2021. Audit included inspection of blinds and window coverings, condition of furniture in room, baseboards and sheet rock. Items with sharp edges were immediately removed or repaired. Beginning 01/10/2022, Resident rooms will be monitored by means of rounds with the Administrator, Housekeeping Supervisor and Maintenance Director weekly for two months, then monthly for two months. A list of any areas of concern will be compiled and completion date of repairs will be tracked by the Maintenance Director and reviewed weekly by the Administrator for two months to ensure all work orders are completed timely. 4. The Administrator will compile a list of repairs monthly and present to the Quality Assurance and Performance Improvement Committee for review and	

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F 584	Continued From page 8	F 584		

the room needed repair due to the damage done by the beds being raised up and down. The ADM confirmed the floors needed cleaning. She stated that the D hall was worse. The ADM stated that the housekeeper should have seen the wall between D11 and D13 and cleaned it. The ADM stated that the condition of the wall and baseboards in Room D14 was unacceptable. The ADM stated staff members are to do daily walk throughs in assigned areas. She stated that all these things should have been reported. The ADM confirmed the wall behind the bed in Room C9A was damaged. The gouged area was measured by the Administrator at 25.5 inches long by 4 inches wide by 2 inches deep. She confirmed that the wall behind the bed in Room C2A was gouged and paint was scuffed off and the entry door to the room was scratched and scuffed. The ADM confirmed the damaged walls, bedside tables and overbed tables, and the dirty wall. She stated that the rough edges could cause skin tears to the residents.

An interview on 12/8/21 at 9:15 AM, with the Maintenance Director revealed Resident #76's window blind was "torn to pieces and not functional". He confirmed that the damage to the wall behind the beds and base boards pulled away from the wall should have been reported and repaired. He confirmed that the floors were dirty and could be cleaner.

An interview on 12/8/21 at 9:20 AM, with Licensed Practical Nurse (LPN) #1 revealed that she had been in Room D14A every day this week. She stated that she had not noticed the damage to the wall and baseboards in the resident's room. She stated that she should have because she was responsible for all aspects of the resident's

recommendations on 01/11/2022, then every month for two months.

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F 584	Continued From page 9 care. An interview, on 12/8/21 at 10:50 AM, with Housekeeping Staff #3, confirmed the floors were dirty. She stated that "they could be better."	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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	F 623		2/11/22

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F 623	Continued From page 10	F 623		

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;
(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

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F 623	Continued From page 11 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 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, record review and facility policy review, the facility failed to provide written notification of a transfer to the hospital for one (1) of two (2) residents reviewed for hospitalization. Resident #76. Findings include: Review of facility policy titled, "Discharge and Transfer Policies-Involuntary", dated 7/2018, revealed, The policy also revealed, "Prior to resident being transferred or discharged, the facility must provide a written notice to the resident, and if known, a family member or legal	F 623	1. On 12/8/2021, the Administrator in-serviced the Business Office Manager regarding facility notification of Transfer/Discharge. 2. Any resident who transfers to the hospital has the potential to be affected. 3. On 12/8/2021 an audit was conducted of transfer in past 30 days by the Administrator with 18 0f 18 transfers affected by this deficient practice. On 12/8/2021, the Business Office	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

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F 623	Continued From page 12 representative of the resident. This must be issued at least 30 days before the resident is transferred or discharged. The written discharge notice must contain the following information: the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged." An interview on 12/7/2021 at 10:00 AM, with Resident #76 revealed that he was in the hospital due to a viral infection and dehydration. He revealed he had diarrhea and was vomiting and was taken to the hospital for intravenous fluid and antibiotics. Resident #76 revealed he did not receive a written notification of going to the hospital or for the bed hold information. An interview on 12/8/2021 at 4:20 PM, with the Business Office Manager, revealed she did not realize that a written notification of bed hold and notification of transfer was needed for this long-term care resident since a 15-day bed hold was in place. She revealed she communicated information of the hospital transfer and bed hold notification to Resident #76 verbally, but did not give the resident this information in writing. She revealed notifications are needed for the resident or the resident representative to have the information for the care of the resident and she is the person responsible for completing these. The Business Office Manager stated, "I'm not gonna lie about it. I just haven't been doing this". An interview with the Administrator on 12/8/2021 at 4:55 PM, revealed the facility failed to provide Resident #76 with the appropriate written notification of transfer with the basis for transfer specified. She revealed the notifications are necessary to keep the resident and the resident	F 623	Manager initiated a Discharge/Transfer log to ensure that written notice of discharge or transfer is provided to the resident or responsible party as soon as is practical. If notification mailed, the Business Office Manager will maintain a log of date notification was mailed. Beginning 12/10/21, the Administrator will review the log weekly for two months. 4. The Administrator will compile findings and bring to the Quality Assurance Performance Improvement committee for review and recommendations on 01/11/2022, then monthly for two months.	

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F 623	Continued From page 13 representatives informed, so they are aware of the resident's care and condition, and available options and requirements. Record review of Resident #76's Physician's Telephone Orders revealed an order dated 10/31/2021 to send to the Emergency Room due to excessive diarrhea and vomiting. Record review of Resident #76's Face Sheet revealed the resident was admitted to the facility on 11/5/2020. Record review revealed the resident with diagnoses of Obstructive Sleep Apnea, Hypertension, Anxiety, Schizophrenia, Bipolar Disorder, and Acquired absence of left and right leg below knees. Record review of Minimum Data Set (MDS) dated 10/21/2021, Section C, Cognitive, revealed Resident #76 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625		2/11/22

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F 625	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, record review and facility policy review, the facility failed to provide written notification of bed hold policy for one (1) of two (2) residents investigated for hospitalization. Resident #76. Findings include: Review of facility policy titled, "Discharge and Transfer Policies-Involuntary", dated 7/2018, revealed, "Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and the resident representative or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding bed-hold policies." An interview on 12/7/2021 at 10:00 AM, with Resident #76 revealed that he was in the hospital due to a viral infection and dehydration. He	F 625	1. On 12/8/2021, the Administrator in-serviced the Business Office Manager regarding facility notification of Transfer/Discharge and Bed hold Policy. 2. Any resident who transfers to the hospital has the potential to be affected. 3. On 12/8/2021 an audit was conducted of transfers in past 30 days by the Administrator with 18 0f 18 transfers affected by this deficient practice. On 12/8/2021, the Business Office Manager will maintain a Discharge/Transfer and Bed Hold log daily to ensure that written notice of discharge or transfer and Bed hold Policy is provided to the resident or responsible party as soon as is practical. If notification mailed, the Business Office Manager will maintain a log of date notification was mailed.	

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F 625	Continued From page 15 revealed he had diarrhea and was vomiting and was taken to the hospital for IV fluid and antibiotics. Resident #76 revealed he did not receive the bed hold information. An interview on 12/8/2021 at 4:20 PM, with the Business Office Manager, revealed she did not realize that a written notification of bed hold and notification of transfer was needed for this long-term care resident since a 15-day bed hold was in place. She revealed she communicated information of the hospital transfer and bed hold notification to Resident #76 verbally, but did not give the resident this information in writing. She revealed notifications are needed for the resident or the resident representative to have the information for the care of the resident and she is the person responsible for completing these. The Business Office Manager stated, "I'm not gonna lie about it. I just haven't been doing this". An interview with the Administrator on 12/8/2021 at 4:55 PM, revealed the facility failed to provide Resident #76 with the notice of bed hold. She revealed the notifications are necessary to keep the resident and the resident representatives informed, so they are aware of the resident's care and condition, and available options and requirements. Record review of Resident #76's Physician's Telephone Orders revealed an order dated 10/31/2021 to send to the Emergency Room due to excessive diarrhea and vomiting. Record review of Resident #76's Face Sheet revealed the resident was admitted to the facility on 11/5/2020. Record review revealed the resident with diagnoses of Obstructive Sleep	F 625	Beginning 12/10/21, the Administrator will review the log weekly for two months. 4. The Administrator will compile findings and bring to the Quality Assurance Performance Improvement committee for review and recommendations on 01/11/2022, then monthly for two months.	

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F 625	Continued From page 16 Apnea, Hypertension, Anxiety, Schizophrenia, Bipolar Disorder, and Acquired absence of left and right leg below knees. Record review of Minimum Data Set (MDS) dated 10/21/2021, Section C, Cognitive, revealed Resident #76 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645		2/11/22

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F 645	Continued From page 17	F 645		

and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

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F 645	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure a Preadmission Screen and Resident Review (PASARR) Level II Screen was completed for one (1) of six (6) residents reviewed for PASARR. Resident #93. Findings include: The facility has no policy related to PASARR. Record review of the Pre-Admission Screening (PAS) Application for Long Term Care dated 11/11/21 revealed, "Part B-Level II Referral Criteria: Person has a history of, or presents any evidence of cognitive behavior or behavior functions that indicate the need for an MR evaluation? Yes. Person has a diagnosis of a major mental illness? Yes. Person has a recent history of major mental illness? Yes. Person takes, or has a history of taking psychotropic medication? Yes." Record review revealed there was no PASARR Level II Screen in the medical record for Resident #93. An interview on 12/8/21 at 2:25 PM, with the Social Worker (SW) revealed that she had sent a Pre-Admission Screening (PAS) Level I Screen for resident and did not receive a response. SW stated she sent Resident #93's PAS Level I Screen in at the same time with a bunch more and she was able to find every other resident's proof of the information being faxed but was not able to find the fax confirmation for Resident #93. An interview, on 12/8/21 at 03:40 PM, with the	F 645	1. The Administrator resubmitted Pre Admission Screening and Resident Review on 12/27/2021 for Resident #93. Level II screening results received on 01/05/2022. 2. Any resident admitted with Mental Illness or Developmental Disability have the potential to be affected. 3. The Administrator completed an audit on 12/15/2021 of past 30 days to ensure Level II PASARR for residents with major mental illness or psychotropic medicine completed with Level II, with 5 of 19 residents affected by this deficient practice. Corrective action was completed by the Administrator on 01/07/2022 related to these findings. On 12/15/2021, the Administrator or Social Services Director will complete PASARR upon admission and the tracking log will be completed for tracking of PASARR/Level II screenings. Beginning 12/15/2021, the Administrator will review the log weekly to ensure deficient practice will not recur. 4. The Administrator will compile a list of findings and present to the Quality Assurance Performance Improvement Committee for review and recommendations on 01/11/2022, then monthly for two months.	

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F 645	Continued From page 19 SW confirmed that she did not follow up on the PAS Level I Screen within 30 days after Resident #93 admitted to the facility, and that Resident #93 was not referred to a mental health service agency for a PASARR Level II Screen. An interview on 12/8/21 at 3:40 PM, with the Administrator (ADM) revealed if a resident is noted to have a major mental illness on a PAS Level I Screen, with no primary diagnosis of Alzheimer's Disease or Dementia, they usually get a response for need for a PASARR Level II Screen. The ADM stated she remembered she received a call from the Mississippi (MS) State Department of Mental Health about Resident #93's PASARR Level II Screen, but the MS State Department of Mental Health would not come to the facility, because the facility had a COVID-19 outbreak at that time. The ADM stated she does not remember who she spoke with from the MS State Department of Mental Health and did not document the conversation. Record review of the Face Sheet revealed Resident #93 was admitted to the facility on 7/30/21 with diagnoses that included Schizoaffective Disorder, Unspecified, Paranoid Schizophrenia, and Other Anxiety Disorders.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		2/11/22

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F 656	Continued From page 20 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to complete a smoking care plan for a resident who smokes for one (1) of two (2) smoking care	F 656	1. On 12/8/2021, The Minimum Data Set (MDS) Registered Nurse updated the smoking care plan for Resident #4.	

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F 656	Continued From page 21 plans reviewed. Resident #4. Findings include: Review of the facilities Smoking Policy dated 11/17 revealed under policy: "Smoking is to occur only in designated areas and in accordance with each smoking resident's individualized plan of care based on the Smoking Safety Evaluation". An observation on 12/07/21 at 10:30 AM, of Resident # 4 attending the 10:30 smoking session revealed the resident was smoking. Record review of Resident #4's "Smoking Safety Evaluation" dated 06/23/21 revealed Resident #4 had range of motion limitations, "Bilateral amputee." Interventions included "Smoke with supervision by staff, Smoker apron, Facility to store smoking items (tobacco/lighter/matches)". The area for "Care Plan Concern" was left blank and was not marked as yes or no. An interview on 12/8/21 at 11:25 AM, with Licensed Practical Nurse (LPN) # 1 revealed if the resident did not have a smoking care plan, then he should. An interview on 12/8/21 at 11:30 AM, with the Director of Nurses (DON) confirmed that the resident had a completed smoking assessment but did not have a smoking care plan on the medical record. An interview on 12/8/21 at 11:34 AM, with Registered Nurse (RN # 1), the Minimum Data Set (MDS) Nurse confirmed that the resident did not have a smoking care plan, but that it was on her "to do" list.	F 656	2. Any resident residing in the facility who smokes has the potential to be affected. 3. The Director of Nursing completed an audit of residents who smoke on 12/15/2021. 21 of 21 residents audited with no negative findings. On 12/15/2021, the Administrator in-serviced the MDS RN, Director of Nursing, and Assistant Director of Nursing regarding the facility policy for completion and updating of the resident care plans. Beginning 12/15/2021, the DON will conduct an audit of resident smokers to ensure care plan in place weekly for one month, then monthly for two months. 4. The Administrator will bring audit findings to the Quality Assurance Performance Improvement committee for review and recommendations on 01/11/2022, then monthly for two months.	

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F 656	Continued From page 22 Record review of the Face Sheet revealed Resident #4 was admitted to the facility on 05/3/21 with diagnoses that included Nicotine dependence, cigarettes. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/2/21 revealed a Brief Interview for Mental Status score of 15 indicating Resident #4 was cognitively intact.	F 656		
F 677 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 and resident interviews, record review and facility policy review, the facility failed to provide nail care, facial shaving, and hair washing for two (2) of eight (8) residents observed. Resident #4 and Resident #59. Findings Include: Record review of Bath/Shower-Dependent policy, HISTORY ...8/11 revealed, "POLICY: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. RESPONSIBILITY: Nursing Assistants or Licensed Nurses monitored by Charge Nurse". This policy revealed under Procedure: # 12 "Shampoo hair unless done by beautician ..."	F 677	1. On 12/9/2021, the Director of Nursing trimmed and cleaned the fingernails for Resident #4. On 12/10/2021, per his request, Resident #4 received a shower and shampoo. On 12/9/2021, Resident #59 received a shower with shave and shampoo by the certified nurse assistant. 2. Any resident residing in the facility has the potential to be affected. 3. On 12/10/2021, the Director of Nursing initiated education with direct care staff regarding Activities of Daily Living care and documentation. On 12/13/2021 an audit of nail care for	2/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23 Review of A.M. Care Policy, HISTORY 10/09 revealed, POLICY: A.M. Care will be given to residents daily. RESPONSIBILITY: All Nursing Assistants ...PROCEDURE: ...10. Provide nail care as needed 11. Provide/assist with shaving (male and female) as needed ..." Resident #4 An observation on 12/06/21 at 11:45 AM, revealed Resident # 4 sitting in the dining room eating lunch with his hands. Resident # 4's fingernails had a brown substance on top and under all of his fingernails, hair stubble on his face and his hair appeared greasy and unwashed. An interview on 12/8/21 at 9:20 AM, with Resident #4 revealed that he tries to clean his own nails and prefers to eat with his hands. Resident #4 revealed he would like to have his nails trimmed and filed. An observation on 12/9/21 at 8:53 AM, revealed that Resident # 4's nails had a brown substance under them and were long. An interview on 12/9/21 at 9:03 AM, with Certified Nursing Assistant (CNA) #4 revealed that when the residents get a bath, the CNAs cut nails, shave, wash hair and blow dry their hair if they want that done but confirmed that that is not something that they have to document in the computer system. During an interview and observation on 12/9/21 at 12:00 PM, with the Director of Nursing (DON) and Resident #4, the DON confirmed that Resident #4	F 677	residents was completed by the DON, Assistant DON, Treatment Nurse, and charge nurse to ensure all residents were provided nail care per resident preference. Any identified concerns were addressed at that time. The DON initiated education on 12/13/2021 with nurses and nursing assistants in regards to ADL's, nail care, and documentation of care refusals. In-services to be completed by 12/27/2021. Newly hired nurses and nursing assistants will be in-serviced during orientation by the DON or Staff Development Coordinator. Beginning 12/10/2021, 10% observation of ADL care to include verification of showers, shave and nail care will be completed by the DON weekly for 8 weeks, then monthly for two months utilizing the ADL audit tool. Any areas of identified concern will be addressed by the DON. 4. The Administrator will present the findings of the ADL audit tools to the Quality Assurance Performance Improvement Committee for review and recommendation on 01/11/2022, then monthly for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

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F 677	Continued From page 24	F 677		

needed his nails cleaned and trimmed and stated "he refused to let me cut his nails yesterday." Resident #4 stated that he wanted his nails trimmed and needed them cleaned.

Record review of Resident # 4's Care Plan with a problem onset date of 5/3/21 revealed, "Problem/Need ... I require assist with my ADLs (Activities of Daily Living) related to impaired mobility." The goal for this care plan was, "My ADL needs will be met thru next review date ...Approaches ... Assist me with my shower/bath 3x (three times) weekly and as needed."

Record review of Resident # 4's Face Sheet revealed he was admitted to the facility on 05/03/21 with diagnoses including Encounter for orthopedic aftercare following surgical amp, Anemia, Acquired absence of right leg below knee, and Acquired absence of left leg below knee.

Record review of Resident # 4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/2/21 revealed a Brief Interview for Mental Status of 15 indicating full cognitive ability.

Resident #59

An observation on 12/07/21 at 08:55 AM, of Resident # 59 revealed he has hair growth on his chin and above his lip with hair stubble on his cheeks and his hair appeared greasy and unwashed.

Record review of Resident # 59's Face Sheet revealed an admission date of 07/17/20 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Dementia, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 25	F 677		

Depressive Disorder.

Record review of Resident # 59's Care Plan with a problem onset date of 7/22/2020 revealed "Problem/Need I require assist with my ADLs (Activities of Daily Living) related to impaired mobility and incontinence". The goal for this care plan was "My ADLs will be met thru next review date." The interventions for this care plan included, " ...Assist me with my shower/bath 3x (three times) weekly and as needed".

An interview on 12/8/21 at 9:40 AM, with the Director of Nurses (DON) revealed that the residents are on a schedule for their baths or showers, and they can request different days. The DON revealed that Resident #4 had three baths per week documented. The DON revealed the Certified Nursing Assistant(CNA)s document when showers occur and if the resident refuses, they are to tell the nurse. The DON revealed that the CNAs document when the resident has a bath, but there is no specific place in the computer system for the CNA to document about particular things like nail care and shaving. The DON revealed that the CNAs know that nail care and shaving is just part of a bath.

An interview on 12/9/21 at 11:00 AM, with Assistant Director of Nurses (ADON) verified there is
no area in their computer system for the CNAs to document specifics about the residents' baths such as nail care and shaving. The ADON verified that there was no place for the nurse to verify that the residents nail care and shaving had been completed. The ADON verified that an area would have to be added to our system for them to document nail care and shaving and that it

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	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 26 doesn't let the CNAs know to perform that area of care.	F 677		
F 880 SS=E	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 §483.70(e) 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;	F 880		2/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

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TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 (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 interviews, and facility policy review, the facility failed to perform hand hygiene to prevent the likelihood of infection transmission as evidenced by improper hand hygiene during meal tray pass for two (2) of four (4) halls and the dining room.	F 880	1. Director of Nursing (DON) initiated in-servicing of direct care staff (nurses and certified nursing assistants) on 12/6/2021 regarding hand washing, hand-hygiene during meal service and tray delivery.	

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	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28 Findings include: Record review of facility policy titled "Hand Washing", history 9/19, revealed, " POLICY: Staff will use proper hand washing technique to prevent the spread of infection." Record review of the facility procedure titled "Proper Hand Washing and Glove Use", no date, revealed "Guideline: All employees will use proper hand washing procedures and glove usage in accordance with State and Federal Sanitation Guidelines. Procedure: ...4. Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident ... 7. Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for break, or to go to another area for break, or to go to another location in the building; after handling potentially hazardous food, or if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. 8. Staff should be reminded that gloves become contaminated just as hands do and should be changed often. When in doubt, remove gloves and wash hands again. 9. When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves is applied. Gloves are never placed on dirty hands; the procedure is always wash, glove, remove, rewash, and re-glove." On 12/06/21 at 11:40 AM, an observation of meal tray pass in the dining room revealed Certified Nurse Assistant #2 (CNA) cleaned her hands with hand gel upon entry to the dining room, she	F 880	2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. Beginning 12/20/2021, the Director of Nursing will conduct an audit of hand washing/hand hygiene during meal service and tray delivery using a quality assurance audit tool. Audit will be conducted three times weekly for two weeks, then weekly for four weeks, then monthly for two months. Any areas of concern will be addressed and education provided. Upon hire, staff will be educated regarding the policy for Hand hygiene and Infection Control during meal service and tray delivery. Beginning 01/11/2022, the Administrator, DON, and Charge Nurse initiated education to all staff as part of Directed Plan of Correction (DPOC) from Centers of Disease Control (CDC): "Sparkling Surfaces" and "Clean Hands". Education will be completed by 01/17/2022. On 01/10/2022, the Root Cause Analysis was completed with the Administrator, Director of Nursing, Registered Dietician and Dietary Service Manager 4. The Administrator will compile audit tools and present findings to the Quality Assessment Performance Improvement for review and recommendation on 01/11/2022, then monthly for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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F 880	Continued From page 29	F 880		

passed out three residents' trays without cleaning hands between residents. She also touched her forehead, adjusted her face mask and did not utilize hand hygiene.

On 12/06/2021 at 12:07 PM, an observation of the meal tray pass for A Hall revealed CNA #1 donned a pair of gloves and began passing trays. She wore the same pair of gloves from room to room returning to the tray cart for other trays without cleaning hands or utilizing alcohol hand gel. CNA#1 touched her forehead with the gloves and touched her mask with the gloves. She removed the gloves after she completed passing all the trays on the hallway.

On 12/06/21 at 2:50 PM, during an interview with CNA #1, she confirmed she wore the same pair of gloves during the tray pass at noon today. She reported using the same gloves to pass the trays could cause the spread of germs and she admitted she didn't change gloves during meal pass.

On 12/6/21 at 3:00 PM, an interview with CNA #2 revealed when asked how was she supposed to utilize hand hygiene when passing residents food trays, she replied that she should wash hands or use hand gel between each meal tray pass. The State Agency (SA) asked her did she clean her hands today when passing meal trays at noon, she reported no, she did not clean her hands between each tray she passed. The SA asked her what could be the outcome of not properly utilizing hand hygiene between passing trays, CNA #2 replied that it could cause a spread of germs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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F 880	Continued From page 30 Surveyor: Mix, Michell An observation on 12/6/21 at 12:00 PM of two CNAs (CNA#5 and CNA#6) passing out lunch trays on the C Hall revealed the CNAs did not use sanitizer or wash their hands between residents. CNAs were observed setting up the resident trays and returning to the food cart, picking up and delivering and setting up trays from room to room. An interview, on 12/6/21 at 03:01 PM, with CNA #5, revealed she did not wash her hands between passing out resident trays for most of the residents. CNA #5 stated she did sanitize her hands between a few residents, but stated it was wrong not to sanitize her hands between all the residents. CNA stated she could have caused cross contamination by not sanitizing her hands between residents. CNA #5 stated she had an in-service on cross contamination and hand hygiene when she hired into the facility, as a PRN (as needed) staff member, 2 months ago. On 12/08/2021 at 4:30 PM, an interview with the Director of Nursing (DON) revealed the staff are supposed to utilize hand hygiene between passing trays to residents. The staff at the facility are not supposed to go from resident to resident wearing the same gloves. The SA asked what the outcome could be by not utilizing hand hygiene between resident tray pass, the DON replied that not cleaning hands between tray pass could lead to the spread of infection.	F 880		
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured	F 924		2/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 924	Continued From page 31 handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain handrails that were secured and affixed to the walls for one (1) of four (4) hallways. Hallway D Findings Include: An observation on 12/08/21 at 8:00 AM, revealed D Hall handrails missing between rooms D9 and D11, rooms D8 and the conference room door, between rooms D5 and D6, and D3 and D4. The curved edges were not on the ends of the remaining side rails leaving the ends with sharp silver-colored exposed edges. These sharp edges were located outside the medical records door, room D11, room D13 and outside the data processing door and remaining rails were not well secured to the walls and were loose on Hallway D. An interview on 12/8/21 at 8:05 AM, with the Administrator revealed she was aware of issues with the handrails missing and being loose. She stated that she was not aware of the rough sharp edges exposed. She stated that this could cause skin damage/tears to the residents and that the residents who are on that hall would use the handrails. The Administrator stated they did not have a policy to address handrails, to maintain them in a safe and secure manner.	F 924	1. On 12/8/2021, the Maintenance Director covered edges of hand rails to prevent injury. On 12/16/2021, the Administrator submitted order for handrails to D corridor. On 01/05/2022, the Maintenance Director initiated installation of temporary hand rails to be in place until permanent hand rails arrive at facility. Plan for completion of hand rail replacement to be completed by 01/17/2022. 2. Any resident residing in the facility has the potential to be affected. 3. On 12/8/2021, the Administrator and Maintenance Director conducted an audit of hand rails to all other corridors (A, B, C) with no negative findings. Beginning the week of 12/17/2021, the Maintenance Director and Administrator to monitor compliance by observation rounds (hand rails secured to wall, temporary coverings to any uneven edges in place, no other broken or rough edges noted to hand rails) weekly for four weeks then monthly for two months. 4. The Administrator will bring results of findings to the Quality Assurance Performance Improvement committee for review and recommendations on 01/11/2022, then monthly for two months.	