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 _____	05/18/2023

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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and complaint investigations (CI MS #21447 and CI MS 21099) at the facility from 5/16/23 through 5/18/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F576, F656, F697, F758, F761, and F880. The SA found the facility to be in compliance related to CI MS #21447 and found the facility to not be in compliance related to CI MS #21099 and cited F677 related to activities of daily living. The Facility held a license for 120 beds at the time of the survey, and the facility census was 111.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		6/23/23

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

Electronically Signed | 06/01/2023

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F 576	Continued From page 1 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident, staff interviews and facility policy review, the facility failed to provide mail services to the residents on Saturday for five (5) of five (5) residents interviewed during the resident council meeting. This has the potential to affect all 111 residents. Findings include; Record review of the Facility Policy titled "Review of the Resident Bill of Rights" revealed each resident has a right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or	F 576	Please consider this Plan of Correction as Tupelo Nursing and Rehabilitation Center LLC credible allegation of compliance. This Plan of Correction in response to the statement of deficiencies demonstrates our good faith and desire to continue to improve the quality of care and services rendered to our residents. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. The facility will provide all residents the Rights to Forms of Communication w/	

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F 576	Continued From page 2 enhancement of (his or her) quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights as a citizen of the United States without interference , coercion, including those rights specified herein: A. Facility Residents shall have the right to:... #26. To send and receive mail promptly and unopened. On 5/17/23 at 11:25 AM, during the resident council meeting with five residents with Brief Interview for Mental Status (BIMS) scores of either 14 or 15 (which indicated intact cognitive skills) revealed the residents are not receiving mail on Saturdays. An interview on 5/17/23 at 5:05 PM, with the Hospitality Aide revealed she works 7:00 AM to 7:00 PM and is only off on the third week-end of the month. She stated she gets the mail and sets it in the Administrative Assistant's (AA) window and the AA separates it on Monday and gives her the resident's mail to deliver. She stated that residents do get mail delivered on Saturdays and are not able to get it until Monday. She stated that she does not go through the mail. An interview, on 5/17/23 at 5:10 PM, with the Administrative Assistant (AA) revealed the staff or the hospitality aide gets the mail. She stated the mail comes to the box by the road. She stated they put it in her window or keep it at the nurses station and occasionally mail is still in the box on Mondays. She stated that the mail needs to be distributed on Saturday regardless. An interview on 5/17/23 at 5:25 PM, with the Administrator (ADM) revealed the mail should be delivered when it arrives, including Saturday. She	F 576	Privacy according to Regulations and Rights 483.10 1.The facility failed to provide mail services to the residents on Saturday for five residents who were interviewed. The mail for residents were being delivered on Monday mornings.Beginning 5/19/2023 the Executive Director assigned all members of the Quality Improvement team to weekend management which includes the task of personal mail being delivered to residents beginning 5/20/2023. 2.All residents residing in the facility have the potential to be affected. 3.On 5/19/2023 the Administrator initiated education and in-service with the Quality Improvement team (QI) on Resident Rights that included delivering personal mail to residents on Saturdays during weekend management duties. 4.Beginning the weekend of 5/20/2023 The assigned weekend QI employee will list all residents receiving mail on the observation weekend manager report and deliver to Executive Director each Monday beginning 5/22/2023. Beginning the week of 5/22/2023 the Executive Director will review the weekend observation report for compliance and follow up with residents listed on the observation report. Beginning 5/22/2023 the Executive Director will meet with Resident Council	

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F 576	Continued From page 3 stated they do not have a specific policy on mail delivery.	F 576	President monthly times three months to ensure no issues regarding Residents Rights with receiving mail. The continuation of mail being delivered on Saturdays will be ongoing. Beginning 6/23/2023 the Executive Director will present the observation reports to the Quality Assurance Committee monthly times three months for review. The Quality Assurance Committee will determine the frequency of the audits based upon results achieved.	
F 656 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).	F 656		6/23/23

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F 656	Continued From page 4 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to develop and/or implement a care plan related to finger nails, shaving and medications for three (3) of 24 care plans reviewed. Resident #75, Resident #77, and Resident #99. Findings include: Record review of the facility policy titled, "Comprehensive Person Centered Care Plan" revealed, "Policy: Each resident will have a person centered plan of care to identify problems,	F 656	1.On 5/18/2023 the Minimum Data Set (MDS) Coordinator Registered Nurse (RN) updated Resident #75 care plan to include the anticoagulant medication. On 5/17/2023 the Licensed Practical Nurse (LPN) for resident #77 cleaned and trimmed resident's nail and shaved facial hair. On 5/17/2023 the Assistant Director of Nursing (ADON) Registered Nurse cleaned and trimmed Resident #99 nails.	

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F 656	Continued From page 5 needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care...Procedure: 1. The Comprehensive Person Centered Care Plan shall be fully developed within 7 days after completion of the Admission MDS Assessment...6. Assigned disciplines will be identified to carry out the intervention..." Resident #75 Record review of the comprehensive care plans for Resident #75 revealed no care plan for anticoagulant medication. Record review of the Physician Orders for Resident #75, revealed an order dated 3/15/23, "Eliquis 5 mg (milligrams) tablet one (1) tablet by mouth twice daily." An interview with the Director of Nursing (DON) on 5/18/23 at 9:20 AM, confirmed that Resident #75 did not have a comprehensive care plan for anticoagulant medication. She revealed that the resident took Eliquis twice daily and stated," It should be in the comprehensive care plan". She revealed that the care plan told the staff about the care the resident should receive. She confirmed that by looking at Resident #75's comprehensive care plan, staff would not know that she took a blood thinner and was at risk for bleeding. An interview with the Minimum Data Set (MDS) Coordinator on 5/18/23 at 10:35 AM, confirmed that she could not locate a care plan for anticoagulant medications for Resident #75. She stated that the purpose of the care plan was to address what was going on with the residents. When the Survey Agent (SA) questioned how the staff would know the resident was taking	F 656	2.All Residents residing in the facility have the potential to be affected. 3.On 5/22/2023 the Director of Nursing (DON) in-serviced MDS Coordinator RN and MDS Assistant LPN on Comprehensive Care Plans being completed after MDS assessments. On 5/22/2023 an in-serviced was initiated by the DON with all Registered Nurses ensuring care plans for nail care with residents with diabetes are followed. On 5/22/2023 the ADON and Unit Manager RN completed 100% audit of all residents on anticoagulant therapy to ensure care plan accuracy. On 5/22/2023 an educational in-service was initiated by Staff Development Coordinator (SDC) with all Licensed Nursing personnel and Certified Nursing Assistants (CNA) on Activities of Daily Living (ADL) care noting facial hairs and fingernails. On 5/22/2023 an educational in-service was initiated by SDC with all Licensed Nursing personnel regarding weekly skin assessment to include if nail care is needed or provided. 4. Beginning week of 5/22/2023 the DON will audit ten Residents 'care plan weekly time four weeks for two months to ensure that care plans are accurate. Any	

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F 656	Continued From page 6 anticoagulant medication without a care plan developed, she stated, " They wouldn't know." She stated, "Human error." Record review of the Face Sheet for Resident #75 revealed an admission date of 8/30/22 with diagnoses that included Hemiplegia Following Cerebral Infarction Affecting Right Dominant Side, Cerebrovascular Disease, and Paroxysmal Atrial Fibrillation. Resident #77 Record review of the care plan for Resident #77 with a problem onset date of 1/30/23 revealed " I am at risk for complications related to Diabetes... Approaches... The nurse is to provide my nail care." An observation, on 05/16/23 at 03:41 PM, revealed Resident #77 was unshaven and fingernails were long past the the end of his fingertips. His facial hair is approximately one (1) inch long. An observation and interview, on 05/17/23 at 03:50 PM, with the Director of Nursing (DON) revealed Resident #77 told the DON, concerning his fingernails, "Yeah, they need cutting and I like to be clean shaven." An interview, on 5/18/23 at 12:10 PM, with the DON confirmed the care plan is in place for nail care. She confirmed the care plan was not being followed. Review of the facility Face Sheet for Resident # 77 revealed an admission date of 1/30/23 with diagnoses that included Type 2 Diabetes Mellitus	F 656	concerns will be immediately corrected. Beginning 5/29/2023 the DON will forward the results of the audits to the Executive Director (ED). Beginning 6/23/2023 times three months the ED will forward the audits to the Quality Assurance Committee (QA). The QA Committee will determine the frequency of audits based upon the results achieved. Beginning week of 5/22/2023 the observation of ADL Care to include proper grooming and nail care will be completed by the Unit Managers weekly for eight weeks, then monthly for two months utilizing the ADL audit tool. Beginning 5/29/2023 the audit tools will be given to the DON for review. The DON will forward audit tools to the ED . Beginning 6/23/2023 times three months the ED will present the audit tools to the Quality Assurance Performance Improvement Committee for review and recommendation. The Quality Assurance Performance Improvement Committee will determine the frequency of the audits based upon results achieved.	

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F 656	Continued From page 7 with Diabetic Neuropathy , unspecified, Anxiety Disorder, and Cerebral Infarction. Resident #99 Record review of Resident #99's care plans revealed a care plan for Diabetes, with an approach of " Nails as needed and indicated per RN." An interview and observation on 5/17/23 at 4:02 PM, with the DON confirmed that Resident #99 had long fingernails with a brown substance underneath. She revealed that the CNA that provides direct care to the resident is responsible for cleaning the nails. She stated that the Registered Nurses (RNs) are responsible for cutting the nails. She revealed that the CNA's are supposed to inform the RNs when the residents nails need trimming. She stated that the resident could cause a skin tear or an infection. During an interview with the DON on 5/18/23 at 11:45 AM, the SA inquired whether the staff was following Resident #99's care plan regarding, "Nails as needed and indicated per RN" and she stated, "No, they didn't." Record review of the Face Sheet revealed Resident #99 was admitted to the facility on 10/27/22 with medical diagnoses that included Type 2 Diabetes Mellitus, Diabetic with Chronic Kidney Disease, Cerebral Infarction, and Dementia, unspecified severity.	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	F 677		6/23/23

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F 677	Continued From page 8 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, resident interviews, staff interviews, record review and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care including shaving and nail care for two (2) of 111 residents observed for ADL care. Findings include: Review of the facility policy titled, "Fingernails/Toenails Care", reviewed date of 1/15, revealed, " Policy: The purpose of this procedure to clean the nail bed, to keep nails trimmed, and to prevent infections...Key procedural points revealed that, "Nails can be partially cleaned during bath care...Nail care includes daily cleaning and regular trimming...." Review of the facility policy titled, "Shaving - Male and Female", revealed residents will be free of facial hairs - both male and female. If the resident is alert and oriented and requests not to be shaved, this will be noted in the care plan. Resident #77 An observation on 05/16/23 at 03:41 PM, revealed Resident #77 in the hallway in a wheelchair eating a snack. His general appearance was very unkempt. Resident #77 was unshaven, and fingernails were long past the end of his fingertips. His facial hair was approximately one (1) inch long.	F 677	1.On 5/17/2023 the Licensed Practical Nurse (LPN) for Resident #77 cleaned and trimmed resident's fingernails and shaved facial hair. On 5/17/2023 the Assistant Director of Nursing (ADON) cleaned and trimmed Resident #99 fingernails. 2. All Residents residing in the facility have the potential to be affected. 3. On 5/22/2023 an in-serviced was initiated by the Director of Nursing (DON) with all Registered Nurses ensuring care plans for nail care with residents with diabetes are followed. On 5/22/2023 an educational in-service was initiated by Staff Development Coordinator (SDC) with all Licensed Nursing personnel and Certified Nursing Assistants (CNA) on Activities of Daily Living (ADL) care noting facial hairs and fingernails. On 5/22/2023 an educational in-service was initiated by SDC with all Licensed Nursing personnel regarding weekly skin assessment to include if nail care is needed or provided. On 5/22/2023 an education in-service was initiated by the Executive Director with	

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F 677	Continued From page 9 An observation and interview on 05/17/23 at 09:45 AM, revealed Resident #77 unshaven with facial hair approximately 1 inch long. The resident stated that he would like to be shaved every day and his fingernails need to be cleaned and cut. An observation and interview on 05/17/23 03:40 PM, with Certified Nursing Assistant (CNA) #2 confirmed Resident #77's fingernails were long and needed to be cut and that the resident stated he wanted to be kept clean shaven. CNA #2 stated the resident could cut his skin with long nails. An observation and interview on 05/17/23 at 03:50 PM with the Director of Nursing (DON) revealed Resident #77 told the DON concerning his fingernails, "Yeah, they need cutting." The DON stated that the CNAs should assess nails and report to the nurse if they need cutting, because the CNAs are not allowed to cut nails. She stated the nurses should be assessing the residents. She stated her expectation is if the nails need cutting, they should be cut. An interview on 5/18/23 at 3:30 PM with Registered Nurse (RN) #1 revealed the RNs are responsible for diabetic nail care. She stated they are supposed to do it weekly. RN #1 stated that it is on the Medication Administration Record (MAR) for charting on some residents but not all of them. She stated that she thought the RN supervisors usually do diabetic nail care on the weekends, but the nurses should be assessing the resident's nails. Review of the facility Face Sheet for Resident #77 revealed an admission date of 1/30/23 with diagnoses that included Type 2 Diabetes Mellitus	F 677	Department Managers and Support team on making daily rounds checking assigned residents for needed ADL care. 4.Beginning week of 5/22/2023 the observation of ADL Care to include proper grooming and nail care will be completed by the Unit Managers weekly for eight weeks, then monthly for two months utilizing the ADL audit tool. Beginning 5/29/2023 the audit tools will be given to the DON for review. The DON will forward audit tools to the ED . Beginning 6/23/2023 the ED will present the audit tools to the Quality Assurance Performance Improvement Committee monthly times three months for review and recommendation. The Quality Assurance Performance Improvement Committee will determine the frequency of the audits based upon results achieved. Beginning the week of 5/22/2023 the Department Managers and Support team will conduct daily rounds inspection audits(Residents nail care and proper grooming) The audits will be turned in to the Executive Director each morning in Stand-up meeting for review. Any findings will be immediately addressed. The continuation of daily rounds by Department Managers and Support team will be on-going. Beginning 6/23/2023 the ED will present the audits to the Quality Assurance Performance Improvement Committee monthly times three months for review.	

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F 677	Continued From page 10 with Diabetic Neuropathy, Anxiety disorder, and Cerebral Infarction. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/23 revealed a Brief Interview for Mental Status (BIMS) score of five (5) that indicated Resident #77 was severely cognitively impaired. Resident #99 An observation on 05/16/23 at 10:45 AM, of Resident #99 revealed long thick fingernails extending one-forth (1/4) inch from the tip of fingers bilaterally with a brown substance underneath and a foul odor to hands. An observation on 5/17/23 at 8:20 AM, of Resident #99 revealed long thick fingernails extending 1/4 inch from the tip of fingers bilaterally with a brown substance underneath. An interview and observation on 5/17/23 at 3:45 PM, with CNA #1 revealed Resident #99 did need nails trimmed and cleaned. She revealed that the nails should be cleaned when they become dirty and when the resident received his shower. She revealed that the CNA's are responsible for cleaning the nails and the nurses for cutting. An interview and observation on 5/17/23 at 3:52 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #99 had long fingernails that needed cleaning. She revealed she would have to go check and get back with SA about whose responsibility it was to trim the resident's nails since he is a diabetic. She revealed that the resident could potentially break his skin and	F 677	The Quality Assurance Performance Improvement Committee will determine any recommendations if needed.	

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F 677	Continued From page 11 cause an infection. Interview and observation on 5/17/23 at 4:02 PM, with the Director of Nursing (DON) confirmed that Resident #99 had long fingernails with a brown substance underneath. She revealed that the CNA that provides direct care to the resident is responsible for cleaning the nails and the Registered Nurses (RNs) are responsible for cutting the nails. She revealed that the CNA's inform the nurse when the residents nails need trimming. She confirmed that the resident could cause a skin tear or infection. Record review of the Face Sheet revealed Resident #99 was admitted to the facility on 10/27/22 with medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Record review of the MDS with an ARD of 5/17/23 revealed a BIMS score was not conducted due to Resident #99 is rarely/never understood.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and record review the facility failed to renew a prescription for pain medication for a resident with	F 697	1. On 5/19/2023 the pain management for Resident #40 was reviewed and updated with physician for Resident #40	6/23/23

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F 697	Continued From page 12 constant pain for one (1) of two (2) residents reviewed for pain. Resident #40 Findings include: Record review of documentation on a nursing facility letterhead revealed, "May 18,2023; To whom it may concern, Tupelo Nursing and Rehabilitation Center, LLC, do not have a policy specifically stating the timely ordering of medication." An interview on 05/16/23 at 11:59 AM, with Resident #40 revealed her pain medication runs out and she must wait for it to be reordered by the nurses and delivered to the nursing facility. Resident #40 also revealed her pain medications ran out Monday, 5/15/23 and she did not get another pain pill until Tuesday, 5/16/23. She noted she was told by the nurse, on 5/15/23, that she had no pain pills left and she would get a pain pill when her new prescription arrived. Resident #40 shared that she wanted her pain medication to be available to take to stop her pain. An interview on 5/18/23 at 2:50 PM, with Registered Nurse (RN) #2 revealed she was the nurse assigned to Resident #40 Sunday, 5/14/23, and she gave her the last Hydrocodone-Acetaminophen 7.5-325 milligram (mg) resident had available on that day. RN#2 noted she did not think she needed to be in a hurry to get Resident #2's pain medication filled over the weekend, because Resident #40 told her the Voltaren Gel that was rubbed on her helped her pain. RN #2 noted she requested the new prescription for the Hydrocodone-Acetaminophen 7.5-325 mg on Sunday, 5/14/23, that she received the new prescription on Monday,	F 697	to receive medication on schedule/ routine dosing. 2. All Residents residing in the facility have the potential to be affected. 3. On 5/22/2023 the Staff Development Coordinator initiated an in-service with all licensed staff on the reordering process of medications, notifying the physician for alternate medication if something is not available, and on pain management. 4.Beginning 5/22/2023 the Director of Nursing and/ or Assistant Director of Nursing will monitor and audit the reordering of pain medications and audit residents which are indicated on Section J of Minimum Data Sets two times week for four weeks and then weekly on-going. Any issues or concerns will be immediately addressed.Beginning 5/29/2023 the Director of Nursing will forward the audit tools to the Executive Director for review. Beginning 6/23/2023 the Executive Director will present the audit tools to the Quality Assurance Performance Improvement Committee monthly times three months for review. The Quality Assurance Performance Improvement Committee will determine further recommendations based upon results achieved.	

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5/15/23, and the courier picked the new prescription up and delivered the pain medication back to the nursing facility on Tuesday, 5/16/23. She revealed Resident #40's pain medication should have been reordered when Resident #40 had, at least 10 pain pills left.

An interview on 5/18/23 at 02:55 PM with Resident #40 revealed RN #2 did apply the Voltaren gel on her joints, but it did not completely stop the pain. She noted again that she wanted her pain medication and had kept herself on a regimen to take it at least three (3) times a day to keep her pain down.

An interview on 5/18/23 at 03:05 PM, with the Director of Nursing (DON) revealed Resident #40's pain medication should have been reordered when the last column of her Controlled Drug Record form was started to ensure her pain medication did not run out. She noted the last column contained a reminder message of time to reorder. She confirmed there was a possibility of harm to Resident #40 by her not having her pain medication available to be administered to her to totally relieve her pain.

An interview on 5/18/23 at 03:15 PM, with the Administrator confirmed the nursing staff should have gotten a new prescription timely for Resident #40's pain medication to avoid her pain medicine to not be available to administer to Resident #40 to relieve her pain. There was a possibility of harm to Resident #40 by her not having her pain medication available to totally alleviate her pain.

Record review of the May, 2023 Physicians' Orders for Resident #40 revealed an order dated

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10/6/22 with a start date of 10/6/22 for Hydrocodone-Acetamin 7.5-325 mg, Take one tablet by mouth as needed every 6 (six) hours for the Dx (diagnosis): Chronic Back and Joint Pain.

Record review of the "CONTROLLED DRUG RECORD" for April 7, 2023, to May 14, 2023, for Resident #40, revealed in the last column, on the last line, dated 5/14, the last tablet of Hydrocodone-Acetamin 7.5-325 mg was administered at 12:00 PM, with a signature of RN #2. A note along the side of the column for the last 14 medications administered stated "TIME TO REORDER". From May 1 through May 14th revealed Resident #40 received three (3) or four (4) Hydrocodone-Acetamin tablets daily for pain.

Record review of the "CONTROLLED DRUG RECORD" for Hydrocodone-Acetaminaphen from May 16, 2023, to May 18, 2023, for Resident #40, revealed the resident received 3 tablets on 5/16/23 and 4 tablets on 5/17/23.

Record review of the prescription for Resident #40 revealed an order written on 5/14/23 for Norco 7.5/325mg Tab 1 tab PO (by mouth) q (every) 6 hours PRN (as needed) #120."

Record review of nursing documentation for Resident #40 revealed on 5/15/23, RN #2 received the prescription for Resident #40 for Norco 7.5/325mg and the night shift nurse who gave med driver script (named removed) and dated 5/16/23.

Record review of the 'CONSOLIDATED DELIVERY SHEETS - CONTROLLED SUBSTANCES," for Resident #40, revealed the Norco was received on 5/16/23 at 1:30 AM.

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F 697	Continued From page 15 Record review of Section J - Health Conditions of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/06/2023, for Resident #40, revealed " ... B. Received PRN pain medications: ... 1. Yes ... Pain Assessment Interview ... Pain Presence ... 1. Yes ... Pain Frequency: 1. Almost constantly ... Pain Effect on Function: A. Has pain made it hard for you to sleep at night: ... 1. Yes ... B. Have you limited your day-to-day activities because of pain: ... 1. Yes ... Pain Intensity: A. Numeric Rating Scale (00-10): 10." Record review of the Face Sheet for Resident #40 revealed an admission date of 10/06/22 and a diagnosis of Low Back Pain, Unspecified. Record review of Section C - Cognitive Patterns of the Quarterly MDS Assessment with an ARD of 04/06/2023, for Resident #40, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #40 is cognitively intact.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		6/23/23

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F 758	Continued From page 16 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to ensure that an anti-anxiety, as needed (PRN),	F 758	1. On 5/182023 Lorazepam for Resident #69 was discontinued for non-use. No other residents were affected by this	

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F 758	Continued From page 17 medication had a stop date for one (1) of four (4) residents reviewed for psychotropic medications. Resident #69 Findings include: Review of the facility policy titled, "Behavior Management and Psychopharmacological Medication Monitoring Protocol," with history date of 3/18, revealed, "Policy: Residents who receive... anti-anxiety medication are to be maintained at the safest, lowest dosage necessary to manage the resident's condition....3. PRN psychotropic drugs should be limited to 14 days unless the primary physician has documentation supporting the rational in the medical record and has indicated the duration for the PRN order...." Record review of Resident #69's Physician's Telephone Order dated 12/9/22 for Lorazepam 2 MG(milligrams)/ml(milliliters) Oral Concentrate 0.25-0.5 ML by mouth every (two) 2 hours as needed and a Physician's Telephone Order dated 12/29/2022 for Lorazepam 0.5 MG (ONE) 1 tab by mouth every six (6) hours as needed for Anxiety/Agitation." The record review did not reveal a stop date documented for either medication order. Record review of the "Consultant Pharmacist Communication to Physician," dated 1/29/2023, for Resident #69, revealed the recommendation from the consultant pharmacist "Re: Prn Psychotropic Meds (Duration of Therapy) ... Please evaluate the following therapy (ies) for discontinuation or extended use: Regimen: prn Ativan (pills and/or injection) ... continue therapy	F 758	deficiency. 2. Residents receiving psychotropic medication have the potential to be affected. 3. On 5/22/2023 the Director of Nursing in-serviced Nurse Managers and Social Services to monitor PRN (As Needed) psychotropic medication for stop dates and use. On 5/24/2023 the Director of Nursing and Assistant Director of Nursing did 100% audit of all psychotropic medication for stop dates as indicated. 4.Beginning 5/21/2023 the Pharmacy Consultant will audit and review psychotropic medication each month and forward reports to Director of Nursing and Executive Director, any issues or concerns will be immediately addressed. Beginning 6/23/2023 the Executive Director will present the pharmacy reports to the Quality Assurance Performance Improvement Committee each month times three months for review and recommendations. Beginning 5/22/2023 the Director of Nursing and Social Service Director will audit the use of residents on PRN psychotropic medication weekly times four weeks then monthly. Beginning the week of 5/29/2023 the Director of Nursing will forward the results of the audits to the Executive Director for reviewing. Beginning 6/23/2023 the Executive	

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F 758	Continued From page 18 (ies) for at least 6 months and re-evaluate in January and July." A record review and an interview on 05/18/23 at 12:00 PM, with the Director of Nursing (DON) confirmed that the physician's telephone orders for Lorazepam 2 MG/ml Oral Concentrate 0.25-0.5 ML by mouth every 2 hours as needed, dated 12/9/22, and for Lorazepam 0.5 MG (ONE) 1 tab by mouth every 6 hours as needed, dated 12/29/22, for Resident #69, did not have a stop date documented for the medications. The DON revealed the nursing staff was responsible for assessing the orders for anti-anxiety medication to ensure it had a stop date when the physician's orders were written. She revealed the delay in addressing the need for a 14-day stop date for the 2 orders for the anti-anxiety medication was due to the physician's orders being written after the pharmacist's 12/7/22 visit. She revealed the physician inquiry regarding a 14-day stop date, for the 2 anti-anxiety medication physician's order, could not be submitted until the pharmacist visited the nursing facility in January 2023. The DON confirmed PRN anti-anxiety medication orders should be written with a 14-day stop date and should be reevaluated by a physician to reorder the anti-anxiety medication every 14 days. She confirmed that the Lorazepam could be considered an unnecessary medication for Resident #69. An interview on 5/18/23 at 01:45 PM, with the Administrator confirmed the physician's orders for Lorazepam 2 MG/ml Oral Concentrate 0.25-0.5 ML by mouth every 2 hours as needed, dated 12/9/22, and for Lorazepam 0.5 MG (one) 1 tab by mouth every 6 hours as needed, dated 12/29/22, for Resident #69, should have been	F 758	Director will present the audits to the Quality Assurance Performance Improvement Committee monthly times three months for review and recommendation. The Quality Assurance Performance Improvement Committee will determine the frequency of the audits based upon results achieved.	

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F 758	Continued From page 19 written with a 14 day stop date, and confirmed it could possibly be an unnecessary medication for Resident #69. Record review of the Face Sheet for Resident #69 revealed an admission date of 4/8/19 with a diagnosis of Generalized Anxiety Disorder.	F 758		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility	F 761	1.On 5/31/2023 the Executive Director	6/23/23

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F 761	Continued From page 20 policy review the facility failed to ensure that a lock box was permanently affixed in two (2) of two (2) medication refrigerators observed. Findings include: Review of facility policy titled: "Controlled Medications Administration" revealed, "Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and stated laws and regulations." Record review of a statement on facility letterhead and signed by the Administrator, dated 5/17/23 revealed "...Our facilities policy for narcotic storage does not address that narcotic medications must be kept in a locked container that is permanetly affixed inside a locked refrigerator inside a locked room. As described in F-tag 761." On 05/17/23 at 04:45 PM, observation of the Medication Storage Room #1 on A-B Halls, revealed a locked refrigerator with Insulin, Intravenous antibiotics, Tylenol Suppositories, and Narcotics inside which included Dronabinol, Lorazepam, and Morphine. There were 21 capsules of Dronabinol 2.5mg(milligrams), 30mls of Lorazepam 2mg/ml (milliliters), and 24 milliliters of Morphine Sulfate (100mg/ml) laying on the middle shelf of the refrigerator. There was no storage box with a lock inside of the refrigerator. On 05/17/23 at 5:00 PM, an observation of the Medication Storage Room #2 on C-D Halls	F 761	ordered two (2) locking systems for refrigerator shelf and box by securing with wire cable connections designed to secure and affix to both refrigerator and medication storage box. On 5/31/2023 the facility received two (2) clear medication storage boxes that will affix to the refrigerator and locking system. 2.All residents residing in the facility have the potential to be affected. 3.On 5/31/2023 the Maintenance Director secured the locking system for the refrigerator shelf and the medication storage box to prevent removal. On 5/31/2023 the Director of Nursing (DON) initiated in-service and education to all licensed nursing personnel regarding 483.45 Proper Storage of Drugs. 4. Beginning week of 6/5/2023 the Director of Nursing and/or Unit Manager will conduct on-going weekly audits to ensure no issues or concerns with the security of Medication Storage. Any negative findings will be immediately addressed and corrected. Beginning 6/12/2023 the Director of Nursing will forward the weekly audits to the Executive Director. Beginning 6/23/2023 times three months the Executive Director will present the audits to the Qualtiy Assurance Committee. The Quality Assurance Performance	

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F 761	Continued From page 21 revealed a locked refrigerator with a locked box inside. There were two (thirty milliliter) bottles of unopened Lorazepam inside the locked box which was not permanently affixed. On 05/17/23 at 5:30 PM, an observation of Medication Storage Room #1 and interview with the Director of Nursing (DON), confirmed that there was no locked storage box inside the locked refrigerator and that there were narcotics laying on the shelf. She revealed that she wasn't sure of the regulations and thought the narcotics were supposed to be in a storage box inside the locked refrigerator. She confirmed there was no storage box inside the refrigerator, and it should have been. On 5/17/23 at 5:45 PM, an interview with the Administrator revealed that she did not realize there was not a locked box in the refrigerator on A-B hall and she was not aware of the regulation that the locked boxes were required to be permanently affixed inside the refrigerator. The Administrator also revealed that she would get this taken care of.	F 761	Improvement Committee will review and determine the continuation of the audits based upon results achieved.	
F 880 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.	F 880		6/23/23

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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;
(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

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 _____	05/18/2023

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 23 (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 record review the facility failed to store respiratory equipment in a manner to prevent the possibility of infection, for three (3) of four (4) observations. Resident #7 Findings include: Record review of a statement the facility provided on letterhead dated 5/18/23 that revealed , " We do not have a specific policy for cleaning and storage of individual medical equipment." An observation on 05/16/23 at 11:30 AM, revealed a suction machine with attached tubing and the Yankauer sitting directly on the floor by Resident #7's bedside. The clear, opened packaging was intact over the end of the Yankauer. An observation on 05/16/23 at 3:45 PM, revealed a suction machine with attached tubing and the	F 880	1.On 5/17/2023 the Assistant Director of Nursing (ADON) removed the suction machine and Yankauer from Resident #7 room and cleaned and properly stored it. 2. All Residents residing in the facility have the potential to be affected. 3. On 5/22/2023 the Executive Director initiated in-service and education with Department Managers and Support team on making daily rounds and infection control issues. On 5/22/2023 the Executive Director in-serviced the Housekeeping Staff on proper cleaning of rooms and infection control. On 5/22/2023 the Staff Development Coordinator (SDC) initiated an in-service	

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F 880	Continued From page 24 Yankauer sitting directly on the floor by Resident #7's bedside. The clear, opened packaging was intact over the end of the Yankauer. An observation on 5/17/23 at 8:20 AM revealed a suction machine with attached tubing and the Yankauer sitting directly on the floor by Resident #7's bedside. The clear, opened packaging was intact over the end of the Yankauer. An interview and observation on 5/17/23 at 4:10 PM, with Licensed Practical Nurse (LPN) # 1 revealed that she was the nurse for Resident #7. She revealed she does not recall seeing the suction machine with the Yankauer attached sitting on the floor by the resident's bedside. She revealed that the suction machine and Yankauer should not be stored on the floor due to infection. The suction machine and Yankauer was not on the floor at this time and an attempt to interview with Resident #7 was not successful. Interview with the Director of Nursing (DON) on 5/17/23 at 4:20 PM confirmed that the suction machine had been removed from Resident #7's room. She revealed that a suction machine and Yankauer should not be placed on the floor, and if the suction machine was used after being placed on the floor, it could cause the resident to have a respiratory infection. She revealed that the facility had in-services on infection control in March and May 2023. An interview with the Administrator (ADM) on 5/18/23 at 09:45 AM, confirmed that the suction machine and Yankauer should never be placed on the floor. She stated that the staff knew that leaving a suction machine on the floor could cause issues such as infection. She stated, "They	F 880	and education on Infection Control, room rounds and proper storage of equipment with all licensing personnel and Certified Nursing Assistants. 4.Beginning the week of 5/22/2023 the Department Managers and Support team will conduct daily room inspection audits (Infection control, protective devices and equipment) The audits will be turned in to the Executive Director each morning in Stand-up meeting for review. The continuation of daily rounds made by Department Managers and Support team will be on-going. Beginning the week of 5/22/2023 the Director of Nursing (DON) and/ or ADON will conduct rounds three times week times eight weeks beginning 5/22/2023 to ensure equipment is properly stored and cleaned to prevent infections. Beginning 5/29/2023 the DON will forward the results to the Executive Director (ED) for review. Beginning 6/23/2023 the ED will present the audits to the Quality Assurance Performance Committee monthly times three months for review and recommendation. The Quality Assurance Performance Improvement Committee will determine the frequency of the audits based upon results achieved.	

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F 880	Continued From page 25	F 880		

know that."

Record review of a Hospice Physician's Order dated 11/1/22, revealed, "Suction patient as needed for increased secretions or aspiration. Suction may be provided by hospice nurse during visit or facility nurse if hospice nurse is not present."

Record review of the Face Sheet revealed Resident # 7 was admitted to the facility on 8/07/20 with medical diagnoses that included Personal History of Malignant Neoplasm, Anemia, and Dysphasia.

Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 3/22/23, revealed under section C a Brief Interview for Mental Status (BIMS) score was not completed due to the resident being rarely/never understood.