STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Tupelo	2273 South Eason Boulevard Tupelo, MS 38804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, record review, and facility policy review, the facility failed to notify the State Long-Term Care Ombudsman of a resident's transfer to the hospital, which did not ensure compliance with required notification procedures for resident transfers for one (1) of four (4) hospitalizations reviewed. Resident #46 Findings Include:Record review of facility policy titled, Transfer and discharge date d 11/1/16, revealed 4. Before (Proper name of facility removed) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand; and will also notify the State Long-Term Care Ombudsman . Record review of Resident #46's Order Details revealed an order dated 11/21/25 to send to (Proper name of hospital removed) ER (Emergency Room) for AMS (Altered Mental Status). Record review of the Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman for the month of November 2025, revealed Resident #46 was not listed for his 11/21/25 transfer. During an interview on 1/13/25 at 4:05 PM, the Administrator revealed that she was responsible for the completion and submission of the Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman. She acknowledged that this log provided the Ombudsman with the information on residents transferred to the hospital. She confirmed she failed to place Resident #46's name on the November log for his 11/21/25 admission. Record review of Resident #46's admission Record revealed he was admitted by the facility on 10/24/23 with diagnoses of Gastro-esophageal Reflux Disease and Chronic Obstructive Pulmonary Disease. Record review of Resident #46's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was intact cognitively.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan for two (2) of 28 residents sampled. (Resident #39 and Resident #58) Findings include: Review of facility policy titled Care Plans with effective date: October 2021, revealed, Policy.Care plans are developed by the interdisciplinary team and revied as needed according to resident and patient status or change. Record review of Resident #39's Medication Administration Record (MAR) for January 2026, revealed Resident #39 was currently on an anticoagulant Eliquis five (5) milligram (mg) tablet by mouth (PO) two times a day as of 10/15/25. There was no monitoring for signs/symptoms of bleeding. Record review of Resident #39's Care Plan Risk for complications related to anticoagulant. with review date 10/23/2025, revealed, .Observe for sign and symptoms (S/S) of bleeding example (i.e.) tarry stools, blood in urine, bruising, petechiae. During an interview on 1/12/2026 at 3:41 PM, the Director of Nursing (DON) confirmed there is not an order to monitor for bleeding every (q) shift. She stated her expectations were that any resident on an anticoagulant should have an order on the MAR to monitor for s/s of bleeding. She verbalized the resident was at risk for bleeding because she is taking an anticoagulant. Record review of the admission Record revealed Resident #39 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Unspecified Systolic (Congestive) Heart Failure, and Paroxysmal Atrial Fibrillation. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident # 58 Record review of Resident #58's Care Plan Report revealed an ADL self-care performance deficit related to other failure to thrive including, provide all the effort with the following tasks as this resident is dependent: oral hygiene, toileting hygiene, shower/bathe self . On 1/11/2026 at 4:00 PM, during initial rounds, Resident #58 stated she had received her baths; however, she stated she had not had her hair washed in approximately two weeks and stated she would like her hair washed. On 1/12/2026 at 4:33 PM, during an interview and observation Registered Nurse (RN) #1 was interviewed at the resident's bedside and confirmed the resident's hair appeared unwashed. During an interview on 1/13/2026 at 1:30 PM, the MDS Coordinator confirmed that hair washing is included as part of the resident's ADL care plan. When asked to identify the frequency or specific days the resident was scheduled to have her hair washed, the MDS Coordinator stated it was to occur (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the resident's bath or shower days. The MDS Coordinator further stated the purpose of the care plan is to guide staff how to best provide care for the residents. Record review revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included Cognitive Communication Deficit. Record review of the quarterly MDS with an ARD of 10/20/2025 revealed a BIMS score of 07, indicating mildly impaired cognition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to revise the comprehensive care plan, following a fall, on one (1) of 28 residents sampled. (Resident #83) Findings include:Review of facility policy titled Care Plans with effective date: October 2021, revealed, Policy.Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change .During observation and interview on 1/11/2026 at 3:43 PM, Resident #83 was lying in bed. She was observed to have old, facial bruising. Resident #83 stated she had a fall in her room, but it was a long time ago. She stated, It's almost healed now. Observed that her bed was not in low position during observation. Record review of Post Fall Review with effective date 1/1/2026, revealed, .Date and time of fall: 12/31/2025 21:06 (9:06 PM) .Interventions/recommendations post fall .Recommendations/Interventions .Bed in low position .Care Plan/Kardex updated with new interventions: No .Record review of Resident #83's Risk for Falls care plan with revision date 10/3/2025, revealed, no interventions listed for resident's bed to be in low position.During an interview on 1/13/2026 at 3:09 PM, the Director of Nursing (DON) confirmed that the intervention for bed in low position was not added to the care plan or to the Kardex. She stated, it seems like we did something different with her mattress. She stated that all the beds were supposed to be left in low position. She further stated that the care plan was to be used as a guide on how to provide care for the residents and that the intervention was intended to lessen the possibility of injury should she fall again. Record review of the admission Record revealed Resident #83 was admitted to the facility on [DATE] with medical diagnoses that included Peripheral Vascular Disease, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 02, indicating the resident had severely impaired cognition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to ensure a resident who required assistance received activities of daily living (ADL) care, including grooming and personal hygiene services such as hair washing, in accordance with the resident's assessed needs, for one (1) of 29 residents. (Resident #58) Findings Include: Review of facility policy titled Activities of Daily Living (ADLs), with an effective date of August 2021, revealed the facility policy is to ensure activities of daily living are provided in accordance with accepted standards of practice, the resident's care plan, and reasonable accommodation of the resident's choices and preferences. The policy further identified hygiene activities of daily living to include bathing, dressing, grooming, and oral care. During an interview on 1/11/2026 at 4:00 PM, Resident #58 stated she has received her baths but hasn't had her hair washed in approximately two weeks; she stated she would like her hair washed. During an interview and observation on 1/12/2026 at 4:33 PM, Registered Nurse (RN) #1 was interviewed at the resident's bedside and confirmed the resident's hair appeared unwashed. During an interview on 1/14/2026 at 9:36 AM, Certified Nursing Assistant (CNA) #5 stated she was not familiar with the resident and the past couple weeks she did not wash her hair because she did not want to cause her pain. CNA #5 further stated that now that she knows the resident, she will wash the resident's hair on Mondays, Wednesdays, and Fridays, which are the resident's scheduled shower days. On 1/14/26 at 10:00 AM, the Director of Nursing (DON) stated that the expectations are for the resident's hair to be washed by the CNAs on scheduled shower days. Record review of the admission Record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included Cognitive Communication Deficit. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/2025 revealed a Brief Interview for Mental Status (BIMS) score of 07, indicating severly impaired cognition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure adequate supervision and monitoring for one (1) of 28 residents reviewed following expressions of suicidal ideation, despite receiving post-emergency room recommendations for psychiatric follow-up. (Resident #8) Findings include:Review of facility policy titled, Behavioral Health Services with no date revealed, Each.resident must receive.the necessary behavioral health care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.Interview with Resident #8 on 01/11/26 at 3:45 PM the resident stated that she had been to the emergency room (ER) recently and that she wanted to see a psychiatrist and had not seen one yet.Review of the ER records revealed Resident #8 presented to ER with mood instability and insomnia on 01/10/26. Documentation indicated the resident experienced crying spells and moodiness, with fleeting thoughts of self-harm without plan, intent, or access to means. The resident declined psychiatric admission and stated inpatient care was not necessary. She expressed a desire for outpatient psychiatric follow-up with psychiatrist who visits the facility. The physician documented, Patient appears stable; I do not feel the patient is a risk to herself as she has not endorsed any suicidal ideation at this time. She is in assisted living facility and can receive care from her psychiatrist there for medication adjustment . Documentation further revealed, .Patient states she has been feeling depressed and anxious and wanted to see a psychiatrist, but the (facility name removed) nurses ?wouldn't listen to her' so she made a comment about being suicidal. Upon admission to the ER, patient stated she was not actively suicidal and never had a plan .During an interview on 1/13/2026 at 11:22 AM, Licensed Practical Nurse (LPN) #5 stated Resident #8 returned from the ER at approximately 12:19 AM on 1/11/2026 with no new orders. She stated she confirmed with Emergency Medical Services (EMS) that the resident had not received medication while at the ER; therefore, she administered the resident's nighttime medications and assisted her to bed. She stated the ER did not provide a referral or follow-up orders.During an interview on 1/13/2026 at 11:13 AM, Social Services stated she spoke with Resident #8; however, no documentation was present to support that interaction. She further stated she made a referral on Monday, 1/12/2026, with (Proper Name) Health Services. She stated (Proper Name) Health Services provides weekly visits and that the Master Social Worker (MSW) was in the facility that day and scheduled to see the resident. She stated this behavior was new for Resident #8 and she completed a PHQ9 assessment (questionnaire to screen for depression) upon admission and again in November 2025, and neither assessment indicated concerns. She also stated the resident had experienced multiple room changes due to incompatibility with roommates. Review of the ER document titled [NAME] Telepsychiatry Consult Note dated 1/10/2026, revealed the following recommendations: Medication recommendations: Review and adjust the current antidepressant regimen by facility psychiatric provider. Consider initiation or titration of a non-benzodiazepine anxiolytic appropriate for geriatric patients. Consider sleep-focused pharmacologic intervention (e.g., low-dose trazodone or mirtazapine, if clinically appropriate and not contraindicated). Avoid benzodiazepines if possible given age-related risks unless clearly indicated and closely monitored. 2. Non-Medication/therapeutic recommendations: Urgent psychiatric follow-up at assisted living facility; recommend expedited evaluation rather than routine monthly rounding. Facility staff monitor mood, anxiety, and sleep patterns closely. Encourage daughter's involvement in advocacy and care coordination. Environmental modifications at facility to reduce anxiety triggers (noise reduction, door-open accommodations due to claustrophobia).During an interview on 1/13/2026 at 3:03 PM, the Director of Nursing (DON) confirmed resident was sent to ER as the facility's intervention when the resident stated that she wanted to harm herself. She stated, Since the hospital sent her back to us, we look at that as she's safe to come back to the facility .like (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an ?all clear' to us. That is why we did not put any additional interventions or monitoring into place.Record review of the admission Record revealed Resident #8 was admitted to the facility on [DATE] with medical diagnoses that included Urinary Tract Infection, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Bipolar Disorder, current episode hypomanic, Other Bipolar Disorder, Depression, and Anxiety. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, and record review, the facility failed to ensure catheter care was performed correctly for one (1) of six (6) residents with an indwelling urinary catheter. Resident #70. Findings Include: Record review of the facility's Peri Care Audit Tool (undated) revealed, 11. If Foley catheter present, must wash catheter tube first before starting the peri care. Washes from the meatus up the tube about 6 inches X2 (times two) with changing position of cloth. An observation of Resident #70's catheter care with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:40 PM revealed she prepared to provide catheter care and filled one pan with clean water. CNA #4 wet a washcloth and applied Dynacare shampoo and body wash directly to the cloth. She washed the resident's groin area first, then washed the shaft of the penis, and lastly washed the urinary meatus followed by the catheter. She did not rinse the washcloth with soap between cleaning the different areas of the groin area. An interview with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:54 PM confirmed that she did not use the correct catheter-cleaning sequence during Resident #70's care and acknowledged she did not rinse the soap. CNA #4 explained she was in a hurry and messed up. She acknowledged this could cause the resident to get a urinary tract infection. An interview with the Director of Nursing on 1/12/26 at 4:02 PM confirmed improper catheter-care sequence could cause Resident #70 an infection and that not rinsing soap could cause skin irritation. Record review of the admission Record revealed the facility admitted Resident #70 on 11/3/25 with medical diagnoses including Obstructive and Reflux Uropathy and Urinary Tract Infection. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #70 was moderately cognitively impaired. Section H indicated an indwelling catheter was marked.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility record review, and facility policy review, the facility failed to ensure ongoing monitoring for adverse effects of a medication for one (1) of five (5) residents reviewed for medication review. (Resident #39). Findings include:Review of document on facility letterhead, dated 1/14/26, with the Administrator's signature, revealed, Standards of Practice.The expectation set forth by (facility proper name removed) management is that nurses comply with current standards of practice for residents needing anticoagulant monitoring.Record review of Resident #39's medical record revealed the resident was prescribed Eliquis five (5) milligram (mg) tablet by mouth (PO) two times a day on 10/15/2025; however, the record lacked evidence that nursing staff monitored for signs and symptoms (s/s) of bleeding.On 1/12/2026 at 3:41 PM, during an interview the Director of Nursing (DON) confirmed there was no order to monitor every (q) shift for bleeding. She stated her expectation was that any resident receiving an anticoagulant should have an order on the Medication Administration Record (MAR) to monitor for signs and symptoms of bleeding. She further stated the resident was at risk for bleeding due to anticoagulant use. Record review of the admission Record revealed Resident #39 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Unspecified Systolic (Congestive) Heart Failure, and Paroxysmal Atrial Fibrillation. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, facility policy review, the facility failed to ensure infection prevention and control practices were consistently implemented in accordance with accepted standards of practice. Specifically, the facility failed to maintain oxygen equipment by not dating the oxygen tubing and oxygen humidifier water bottles for Residents #37 and #93 and failed to ensure staff followed Enhanced Barrier Precautions (EBP) by not wearing a gown during Foley catheter care for a resident requiring EBP (Resident #70). These failures affected three (3) of twenty nine sampled residents. Findings Include: Record review of the facility policy titled Oxygen Guideline with an effective date of 1/1/2022 revealed, Medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided in accordance with a health care provider's order and in accordance with acceptable standards of practice. Review of the Infection Control Guide dated 2025 revealed under, System of Isolation for Infection Control: Enhanced Barrier Precautions should be considered when: Any resident with any: . Wound and/or indwelling medical devices (e.g., central lines, urinary catheter. It also revealed under Required: Gloves and gown don prior to the high-contact care activity. Resident #37 An observation on 1/11/26 at 3:45 PM revealed that Resident #37's oxygen tubing and the humidifier water bottle were not dated. A subsequent observation on 1/12/26 at 10:20 AM revealed that the oxygen tubing and humidifier water bottle remained undated. A record review of Resident #37's admission Record revealed the facility admitted the resident on 7/6/25 with diagnoses that included Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Section O revealed that the Resident receives Oxygen therapy. Resident #93 An observation on 1/11/26 at 4:00 PM revealed that Resident #93 was receiving oxygen via an oxygen concentrator. The oxygen tubing and oxygen humidifier water bottle were not dated. An observation on 1/12/26 at 10:20 AM revealed the oxygen tubing and the water bottle remained undated. A record review of Resident #93's admission Record revealed the facility admitted the resident on 11/1/25 with diagnoses that included Chronic Obstructive Pulmonary Disease. A record review of Resident #93's MDS with an ARD of 11/7/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section O revealed that the Resident receives Oxygen therapy. During an interview and observation on 1/12/26 at 3:05 PM, Licensed Practical Nurse (LPN) #4 revealed that the oxygen tubing and water bottles are always to be dated when they are changed, because otherwise we don't know how long the resident has been using the same tubing. She confirmed that the oxygen tubing and water bottle for Residents #37 and #93 were not dated. LPN #4 stated, By not keeping track of when the oxygen tubing and water bottle are changed out, it could set the residents up for a respiratory infection. During an interview on 1/12/26 4:28 PM, the Director of Nurses (DON) revealed the facility previously documented when oxygen tubing and humidifier water bottles were changed; however, we were notified that our policy had changed, and we removed the documentation from our electronic system. The DON stated, oxygen tubing is changed only when visibly soiled and humidifier water bottles are changed only when empty. She confirmed that the facility does not date oxygen tubing or water bottles and acknowledged that there is no method to determine when the equipment was last changed. During an interview on 1/12/2026 at 4:44 PM, the Director of Clinical Care Coordination revealed, I think we should be changing them out weekly, but they have changed the policy now to where the facility only changes the tubing when they notice it is dirty and the bottles when they are empty. She confirmed there was no way to determine when the oxygen tubing or the humidifier water bottle was last changed due to the absence of dating and acknowledged that this practice could place residents at risk of infection. Resident #70 During an observation of Resident #70's catheter care with Certified Nurse Aide (CNA) #4 on 1/12/26 at 3:40 PM, she performed catheter care without applying a gown as required for EBP. During an interview with CNA #4 on 1/12/26 at 3:54 PM, she stated she had the gown ready for use during catheter care but forgot to apply it. She stated the purpose of wearing the gown was to protect the resident from infections. During an interview with the Director of Nursing on 1/12/26 at 4:02 PM, she stated her expectation was for staff to follow Enhanced Barrier Precautions to reduce infection risk. Record review of the admission Record revealed the facility admitted Resident #70 on 11/3/25 with medical diagnoses including Obstructive and Reflux Uropathy and Urinary Tract Infection. Record review of the MDS with an ARD of 11/10/25 revealed under section C, a BIMS summary score of 10, which indicated Resident #70 was moderately cognitively impaired. Section H indicated an indwelling catheter was marked.