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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tupelo Community Care Center	1901 Briar Ridge Road Tupelo, MS 38804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to ensure a call light was maintained within reach for a resident who was dependent for assistance for 3 (three) of 6 (six) residents reviewed. Resident #1, Resident #2 and Resident #5. Findings Include: Review of the facility policy Call Light/Call Pager Systems with effective date of 09/09/22 revealed, .The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room . An observation and interview on 06/10/26 at 9:55 AM revealed Resident #1 lying in bed in his room. He revealed that he had been having trouble with his call light, but he now had a clip attached to the call light cord and he kept it clipped to his clothes. He revealed that prior to having the clip, he had to call his family three or four different times because his call light was on the floor or in the trash can and he couldn't reach it. He revealed that he was not able to get up without help and if he could not reach his call light, he had no way of calling for help. Resident #1 revealed that when he called his family, they called the facility and the staff came in and found it for him. A phone interview on 06/10/26 at 11:00 AM with Complainant, revealed that she visited frequently, and, on several occasions, she had observed his call light not within reach and once noticed it in the trash can. She revealed that Resident #1 had called her three or four times saying that he could not reach his call light, she called the facility and a staff member went down and got it for him. Complainant revealed that Resident #1 was not the easiest person to take care of and could be hateful at times, but he deserved to be taken care of. She further revealed that he was the type of person to get up by himself if he couldn't get someone to help him and she was concerned for his safety. Observations on 06/10/26 at 9:20 AM and at 10:05 AM revealed Resident #2 lying in his bed in his room. His call light was underneath his bed on the floor. Resident #2 revealed that he had a problem with finding his call light often, but mostly in the morning when he wakes up. He revealed that when he can't find his call light, he whistles loudly and hopes they hear him. Resident #2 revealed that he had two strokes back-to-back, and his left side was out and clarified that he could not use his left side. He revealed that he required significant help and depended on the staff to provide it. He also revealed that if no one heard him when he whistled for them, he used his cell phone to call the front desk. He revealed that he can't get up by himself, the staff used a lift to get him up and he needed his call light within reach to be able to call for help when needed. During an interview and observation on 06/10/26 at 10:10 AM with Licensed Practical Nurse (LPN) #1, she confirmed that Resident #2's call light was on the floor underneath his bed and was not within his reach. She revealed that this could prevent him from getting the help that he needed timely. She also revealed that not having the call light within reach could cause a safety issue if he tried to get up and get the call light off the floor himself. LPN #1 confirmed that Resident #2 depended on staff to take care of his needs and that he should have access to the call light at all times. She revealed that all staff were expected to ensure call lights were within reach of the residents after providing care and during rounding. An interview with Director of Nursing (DON), revealed that she wasn't aware of the call light issues with Resident #1. She revealed that she expected all staff to ensure call lights were within reach so residents could remain safe and receive the help they needed timely. She also confirmed that Resident #2 came into the facility following a stroke and that he could not use his left side and that he (continued on next page)

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depended on staff for assistance. DON revealed that Resident #2's call light should not have been under his bed on the floor and that staff should have noticed it and placed it within his reach. An interview on 06/10/26 at 12:00 PM revealed Resident #5 lying in her bed. She revealed that she had concerns with her call light not being within reach sometimes after staff helped her transfer into her chair. She revealed that when she gets out of bed, she sits in a chair near the right side of her bed and staff placed her call light on the left side of her bed out of her reach. Resident #5 revealed that this had happened several times and she's had to yell for someone to help her or get her roommate to use her call light to get help. She revealed that she depended on the staff and she needed to be able to call for help when she needed something. Record review of Resident #1's admission Record revealed an admission date of 06/07/24 and that he had diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction. Record review of Resident #1's Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/05/26 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated that he had moderate cognitive impairment. Record review of Resident #2's admission Record revealed an admission date of 05/27/26 and that he had diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction, and Acquired Absence of Right Leg Above Knee. Record review of Resident #2's MDS with ARD of 06/03/26 under Section C revealed a BIMS score of 15 which indicated that he had no cognitive deficits. Record review of Resident #5's admission Record revealed an admission date of 03/28/26 and that she had diagnoses that included Polyneuropathy and Chronic Obstructive Pulmonary Disease. Record review of Resident #5's Quarterly MDS with ARD of 05/20/26 under Section C revealed a BIMS score of 15 which indicated that she had no cognitive deficits.