

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Tupelo Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>41878</p> <p>Based on observation, resident and staff interview, record review and facility policy review the facility failed to ensure a resident received coffee, as desired, for one (1) of 24 residents sampled.</p> <p>Resident #74</p> <p>Findings included:</p> <p>Record review of facility policy titled, Resident [NAME] of Rights, dated 1/23, revealed, Each resident has a right to a dignified existence, self-determination .in an environment that promotes maintenance or enhancement of (his or her) quality of life .15. Self determination, which the facility must promote and facilitate through support of resident choice, consistent with his or her interests, assessments and plan of care and make other choices about aspects of his or her life in the facility that are significant to the resident. Including but not limited to: activities .and how she or he spends time, both in and outside the facility should be supported to the extent possible.</p> <p>During an interview on 9/9/24 at 12:05 PM, Resident #74 revealed she loved to have coffee each morning, but for the past month, she had not received coffee due to the coffee machine in the kitchen being broken. She stated she received coffee this morning for the first time in weeks, but she was unsure if that would continue. She stated this had also been mentioned in the Resident Council meeting and they were told the coffee machine was being repaired. She revealed that coffee was something that she and many other residents enjoyed and it was a social activity for her and others and not having it had been awful. She stated the facility could have gone to Walmart and bought a coffee pot to make coffee for those residents who wanted it and to go for so long without it was not right or fair for the residents. She stated a lot of money was paid to live at the facility and a basic enjoyable thing like coffee should be given.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 09/10/24 at 11:00 AM, with the Dietary Manager revealed that the facility's coffee maker that was used to make the coffee for the residents had been broken for about two months. She stated that they had been boiling water on top of the stove and using a filter to make some coffee, but there was a delay in getting the coffee to the residents because it was a slow process. She confirmed she had complaints about the coffee machine being broken and understands the residents' frustration. She stated that the Administrator had known about it, and they tried to get someone to repair it, but they never came. She stated someone finally came yesterday and brought a coffee pot as a replacement and this one was working fine.</p> <p>During an interview on 09/10/24 at 11:24 AM, the Administrator confirmed that the coffee pot for the residents had been broken for a while, but she was thinking it had only been a month. She stated she thought someone had already been out to look at the coffee pot before yesterday. She stated that they had a back-up method for making coffee for the residents, but did not realize there was a delay in getting it out to the residents.</p> <p>During the Resident Council on 9/10/24 at 3:15 PM, all of the residents present stated the coffee machine had been broken for several weeks and they were not consistently receiving their coffee and this had been mentioned in the last Resident Council meeting.</p> <p>Record review of Admission Record revealed the facility admitted Resident #74 on 10/13/20.</p> <p>Record review of Resident #74's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/24, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact.</p> <p>44804</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47157</p> <p>Based on observation, staff interview, and facility review, the facility failed to provide housekeeping services necessary to maintain a clean home-like environment for one (1) of 55 rooms observed for a clean environment.</p> <p>Findings include:</p> <p>A review of a document on facility letter head dated 9/10/24 and signed by the Executive Director revealed the facility does not have a policy on cleaning floor mats.</p> <p>An observation of D5 B room on 9/9/24 at 10:20 AM, revealed a light gray fall protection floor mat that was a length of 72 inches by width of 24 inches on the left side of the bed covered in black and brown dried stains. A quarter size clump of a brown leaf tobacco product was observed on the floor next to the floor mat, with a dried brown ring around the tobacco.</p> <p>An observation of room D5 B on 9/09/24 at 2:30 PM, revealed the tobacco product that was lying on the floor had been cleaned up but the floor mat on the left side of the bed remained completely covered in black and brown dried stains.</p> <p>In an observation of the fall mat next to the bed in room D5 B with Certified Nurse Assistant (CNA) #3 on 9/9/24 at 2:30 PM, she revealed the floor mat was filthy and covered with brown and black stains and the floor mat needed to be cleaned.</p> <p>In an interview with the Director of Nursing (DON) on 9/9/24 at 3:10 PM, she revealed the floor mats should be cleaned daily to prevent the spread of infections when staff step on the dirty fall mat.</p> <p>In an interview with Housekeeper #1 on 9/10/24 at 7:45 AM, she revealed the resident's rooms are cleaned daily, and the floors are mopped as well and more often if needed. She stated if a resident has a fall protection floor mat, they should be moved to mop under the mat, and the top of the mat should be sanitized daily to reduce bacteria growth.</p> <p>In an interview with the Assistant Director of Nursing/Infection Control Nurse on 9/10/24 at 10:44 AM, she revealed that the resident's fall mat should be cleaned and sanitized every day along with the room to reduce the risk for spread of infection.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>47157</p> <p>Based on resident/resident representative interviews, staff interview, record review, and facility policy review the facility failed to notify the resident/resident's representative(s) of a notice of discharge/transfer to the hospital in writing and in a language and manner they understand for one (1) of three (3) hospital transfers reviewed. Resident #45</p> <p>Findings include:</p> <p>A review of the facility policy titled, Emergency Transfers Procedures, dated 7/21, revealed, .Procedure: 4.) An Emergency Transfer notice that includes the date, reason for emergency transfer, location the resident is being transferred to and contact information for State Agencies to initiate the appeal process should be provided to the resident/resident representative as soon as is practicable .</p> <p>In an interview with Resident #45 on 9/8/24 at 1:00 PM, she revealed she had been to the hospital recently.</p> <p>Record review of the progress notes for Resident #45 dated 8/29/24 at 11:56 AM revealed the resident was transferred to the emergency department related to chest pains.</p> <p>A record review of the Discharge/Transfer notice for Resident #45 revealed the date of notice as 8/30/24 with no signature from the resident or the resident representative.</p> <p>An interview with the Business Office Manager on 9/10/24 at 12:47 PM, she revealed there is no signature on the Discharge/Transfer form because the forms are mailed out to the responsible party. She revealed she had no proof that the form was ever mailed to the resident representative. She then revealed the purpose of the Discharge/Transfer Notice is to inform the resident representative in writing of the reason for transfer and where the resident was transferred to.</p> <p>A phone interview with the Resident Representative for Resident #45 on 9/10/24 at 3:03 PM, she revealed she has never received anything in person or in the mail regarding notification of discharge/transfer form and stated her mom has been to the hospital a few times.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #45 on 12/16/22 with a diagnosis of Encounter for attention to other artificial openings of the urinary tract.</p> <p>Record review of Resident # 45's Section C of the Quarterly Minimum Data Set (MDS) revealed on 7/26/24 a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>47157</p> <p>Based on resident/resident representative interviews, staff interview, record review, and facility policy review, the facility failed to provide written notice of the bed-hold policy to the resident/resident representative for (1) one of (3) three residents bed holds reviewed. Resident #45</p> <p>Findings include:</p> <p>A review of the facility policy titled, F-625 Notice of Bed-Hold Policy undated revealed, at the time of transfer of a resident for hospitalization , a nursing facility must provide to the resident and the resident representative written notice of the bed-hold policy.</p> <p>In an interview with Resident # 45 on 9/8/24 at 1:00 PM, she revealed she had been to the hospital recently and the facility had not notified her of the bed hold policy when she went out to the hospital, she revealed she did not know what that was.</p> <p>A record review of a Bed-Hold Notice form for Resident #45 revealed the date of notice of 8/30/24 with no signature from the resident or resident representative.</p> <p>In an interview with the Business Office Manager on 9/10/24 at 12:47 PM, she revealed there is no signature on the bed-hold notice form because they are mailed out to the resident representative. She revealed she had no proof that the bed-hold form was ever mailed to the resident representative. She then revealed the purpose of the bed-hold notice is to notify the resident/resident representative in writing about the bed-hold and the amount of the bed-hold, and gives the family the opportunity to make the decision of whether they want to reserve the bed-hold or not.</p> <p>In a phone interview with the Resident Representative for Resident #45 on 9/10/24 at 3:03 PM, she revealed she has never received anything in person or in the mail regarding a bed-hold notice and stated her mom has been to the hospital a few times.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #45 on 12/16/22 with a diagnosis of Encounter for attention to other artificial openings of the urinary tract.</p> <p>Record review of Resident # 45's Section C of the Quarterly Minimum Data Set (MDS) revealed on 7/26/24 a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47874</p> <p>Based on resident and staff interview, record review, and facility policy review, the facility failed to accurately complete section N of the five (5) day Minimum Data Set (MDS) for one (1) of 24 sampled residents. Resident #22</p> <p>Findings Include:</p> <p>Review of the facility policy titled MDS Assessment with a revision date of 6/23 revealed, Policy: The facility shall conduct interdisciplinary assessments using the MDS item sets as defined by Federal/State regulations. These assessments provide information on the resident's condition to facilitate development of an individualized plan of care is as a means by which the facility can track changes in a resident's status.</p> <p>Record review of section N of the Admit 5-day MDS with an Assessment Reference Date (ARD) of 8/26/2024 revealed, Resident #22 was coded to have received seven (7) days of insulin injections during the 7-day look back period since admission.</p> <p>An interview with Resident #22 on 9/9/2024 at 3:55 PM revealed, he was not a diabetic and had never taken insulin injections.</p> <p>Record review of the August 2024 Medication Administration Record (MAR) revealed, Resident #22 did not receive insulin or injections of any kind during the 7 day lookback period.</p> <p>An interview with the MDS Nurse on 9/11/2024 at 7:50 AM, confirmed a coding error was made on the MDS, as Resident #22 did not have a physician order for insulin. She revealed the MDS should be accurate to paint a complete and correct picture of the resident.</p> <p>An interview with the Administrator on 9/11/2024 at 8:33 AM, revealed her expectations were for the MDS assessments to be completed accurately on each resident.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #22 on 7/16/2024 with a medical diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>Record review of the Admit 5-day MDS with an ARD of 8/26/2024 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #22 was moderately cognitively impaired.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>41878</p> <p>Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure a developed care plan was implemented for shaving (Resident #43), bathing (Resident #59), incontinent care (Resident #68, 351, & 352), and nail care (Resident #151) for six (6) of 24 resident care plans reviewed.</p> <p>Findings include:</p> <p>Record review of facility policy titled, Shaving - Male and Female dated 1/15, 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.</p> <p>Record review of facility policy titled, Comprehensive Person Centered Care Plans, revealed, Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care.</p> <p>Resident #43</p> <p>Record review of Resident #43's Care Plan revealed, I require assistance with my ADL's with intervention listed as assist me with my shower/bath three times weekly and as needed.</p> <p>During an interview and observation on 9/9/24 at 10:50 AM, Resident #43 revealed her preference is to have her facial hair removed by shaving, and she had asked staff to assist her with this, but they had not helped her and facial hair was observed on the resident's face.</p> <p>An interview with the Director of Nursing (DON) on 9/10/24 at 2:30 PM, revealed the shower was documented as given yesterday and shaving was a part of the shower/bathing routine and the facility failed to do the shaving. She confirmed the care plan's purpose was to provide resident's preferences and care requirements and Resident #43's care plan for activities of daily living (ADL) was not followed.</p> <p>During an interview on 9/10/24 at 2:33 PM, the Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Assistant confirmed the resident had a care plan for assistance with her Activities of Daily Living (ADL) care which included showers/baths three times weekly. She stated shaving is included in that care and was not done. She confirmed the care plan allows the staff to know what care each resident requires and their preferences for care and she confirmed the facility failed to follow Resident #43's developed care plan for ADL assistance.</p> <p>Record review of Resident #43's Admission Record revealed the facility admitted the resident on 12/18/2020 with diagnoses that included Type 1 Diabetes Mellitus and Arthritis.</p> <p>Record review of Resident #43's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had a mild cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #151</p> <p>Record review of Resident #151's Care Plan date initiated 9/2/24 revealed, The resident has an ADL self-care performance deficit. Interventions included, Check nail length and trim and clean on bath day and as necessary.</p> <p>An observation and interview with Resident #151 on 9/9/24 at 10:50 AM revealed fingernails were long (approximately one-half inch from nail bed) with a brown substance noted under nails. The resident stated she would love for her nails to be trimmed but no one had done it.</p> <p>During an observation and interview with the Director of Nursing (DON) and Resident #151 on 9/10/24 at 4:15 PM, the resident told the DON she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail. She confirmed the care plan for assistance with activities of daily living (ADL) for nail care was not followed for this resident.</p> <p>An interview with the MDS Assistant on 9/11/24 at 9:10 AM, revealed Resident #151's comprehensive care plan for assistance with nail care and activities of daily living had been developed but it was not implemented. She stated purpose of care plan is to provide staff with care required and preferences and should be followed. She confirmed the facility failed to implement the care plan for Resident #151's nail care.</p> <p>Record review of Resident #151's Admission Record revealed the facility admitted the resident on 8/23/24. Diagnoses included Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Need for assistance with personal care.</p> <p>Record review of Resident #151's admission MDS with ARD of 8/30/24 revealed a BIMS score of 9 which indicated the resident was moderately impaired cognitively.</p> <p>Resident #59</p> <p>Record review of Resident #59's Care Plan with a problem onset date of 11/29/23 revealed, I require assistance with ADL's (activities of daily living) r/t (related to) impaired mobility d/t (due to) BIL (bilateral) amputee .Approaches: Shower/Bath resident 3 X (times) weekly .</p> <p>An interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, I'm not going to lie on them or for them . I have not had a bath of any type since last Tuesday; They will wash my face, but that's it. He revealed he would love to be really cleaned up.</p> <p>Record review of documented baths for Resident #59 revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.</p> <p>An interview on 9/11/2024 at 7:45 AM, with CNA #7 revealed, if a resident was supposed to get a bath 3 times per week, and it was care planned, then the care plan was not implemented.</p> <p>An interview on 9/11/2024 at 7:50 AM, with the MDS Nurse revealed, she was one of the staff members responsible for developing the residents' care plans. She confirmed that if a resident had a care plan indicating a resident receives 3 baths a week and did not get them, then the care plan was not implemented.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Admission Record revealed the facility admitted Resident #59 on 11/14/2023 with a medical diagnosis of Need for Assistance with Personal Care.</p> <p>Record review of the Quarterly MDS with an ARD of 7/24/2024 revealed, under section C, a BIMS summary score of 13, which indicated Resident #59 was cognitively intact.</p> <p>Resident #68</p> <p>Review of Resident #68's Care Plans date initiated 8/27/24, revealed under, Focus: The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Hemiplegia, Limited Mobility, Stroke. Also revealed under, Interventions: . Personal hygiene: The resident requires partial assistance by 1 staff with personal hygiene . Toilet use: The resident is totally dependent on 2 staff for toilet use.</p> <p>An interview on 9/9/2024 at 10:20 AM, with Resident #68 revealed, that both Saturday (9/7) and Sunday (9/8) she rang her call light and told the CNA who came in that she was wet and needed to be changed. She revealed on both days the CNA turned the call light off, said she would be back, and left the room without ever coming back. She revealed, last night, her sister called the facility and spoke with the nurse to report that the aide never came back. The resident explained that the nurse and another aide later came to change her. She revealed, I sat in that urine for an hour.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #68 on 8/19/2024 with a medical diagnosis of Chronic Combined Systolic and Diastolic Heart Failure.</p> <p>Record review of the Admission MDS with an ARD of 8/26/2024 revealed, under section C, a BIMS summary score of 13, which indicated Resident #68 was cognitively intact.</p> <p>Resident #351</p> <p>Review of Resident #351's Care Plans date initiated 9/2/24, revealed, Focus: The resident has an ADL (activities of daily living) self-care deficit r/t (related to) Hemiplegia, Limited Mobility, Stroke. Also revealed under, Interventions/Tasks: Personal Hygiene . The resident is totally dependent on 1 staff for personal hygiene . Toilet Use: The resident is totally dependent on 2 staff for toilet use.</p> <p>An observation of Resident #351 on 9/9/2024 at 10:45 AM revealed, he was sitting in a reclining wheelchair in his room. His eyes were open, and he was non-verbal. The resident was wearing a gray pair of jogger pants that were saturated through the groin area and in between the legs with urine. An interview with a family member, while in the room, revealed he was brought back from therapy like this, and nobody had been there since to check on him. The family member revealed the resident's bed was always wet with urine. She revealed the bed was soaked out this morning and had to be changed after they got him up. She stated, They say they are changing him every 2 hours, but they are not because I am here, and they do not enter the room.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #351 on 8/23/2024 with diagnoses including Cerebral Infarction.</p> <p>Resident #352</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #352's Baseline Care Plan dated 9/3/24 revealed under, Bowel and Bladder: . Incontinence care</p> <p>An observation and interview with Resident #352 on 9/9/2024 at 10:58 AM revealed, he was lying in bed and it was noted that a foul odor was around the resident. The resident revealed, after he ate breakfast and took his morning medicine, it was 2 hours before someone could come to clean him up and change him. He stated, They tell me they are working with somebody and will get to me when they can. He revealed the therapy man will even come to his room to take him to therapy, and he must tell him that he cannot go right now because he needs changing. The resident stated, He wouldn't want to sit like that, so he should understand. The resident stated he was still waiting to be changed today.</p> <p>An interview with the Physical Therapy Assistant (PTA) on 9/10/2024 at 11:50 AM revealed, Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8-9 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the residents, but nine times out of ten he cannot find anybody. The PTA stated like yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her, and she went to change the resident.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #352 on 9/3/2024 with medical diagnoses that included Osteomyelitis of vertebra, thoracic region.</p> <p>Record review of the Admission MDS with an ARD of 8/13/2024 revealed under section C, a BIMS score of 15, which indicated Resident #352 was cognitively intact.</p> <p>An interview with the MDS Nurse on 9/11/2024 at 7:50 AM revealed, she does MDS and the care plans. She revealed, if the ADL care was on the care plan, and it was not being done by the staff, then the care plan was not being followed.</p> <p>44804</p> <p>47874</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41878</p> <p>Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide assistance with Activities of Daily Living (ADL's) for residents that were dependent on staff, as evidenced by not being shaved (Resident #43), missed bath (Resident #59), not performing timely incontinent care (Resident # 68, 351 & 352) and long dirty nails (Resident #151) for six (6) of seven (7) residents reviewed for ADL's. Resident #43, 59, 68, 151, 351 and 352.</p> <p>Cross Reference F725</p> <p>Findings include:</p> <p>Record review of facility policy titled, Shaving - Male and Female dated 1/15, 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.</p> <p>Review of the facility policy titled Bath/Shower-Dependent with a revision date of 8/11 revealed, Policy: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. Also revealed under, Responsibility: Nursing Assistants or Licensed Nurses monitored by Charge Nurse.</p> <p>Review of the facility policy titled Incontinent Care with a review date of 1/15 revealed, Policy: To provide routine, preventative skin, perineal care to residents after an incontinent episode. Also revealed under, Responsibility: All Nursing Personnel.</p> <p>Record review of facility policy titled, Fingernails/Toenails Care, dated 1/15, revealed, The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections.</p> <p>Resident #43</p> <p>On 9/9/24 at 10:50 AM, during an interview and observation , Resident #43 revealed her preference was to have her facial hair removed by shaving, and she had asked staff to assist her with this, but they had not. Facial hair was noted on resident's face.</p> <p>An interview and observation of Resident #43 on 9/10/24 at 11:50 AM, revealed facial hair on chin and lower jaw area. She stated she had a shower yesterday afternoon and she wanted her facial hair to be removed, but the staff did not do it.</p> <p>During an interview and observation in Resident #43's room on 9/10/24 at 12:05 PM, the resident informed the Director of Nursing (DON) that she wanted her facial hair shaved, but staff had not done this. The resident informed the DON she had a shower yesterday afternoon, but shaving was not done. The DON confirmed the resident, who required assistance with care, had facial hair present and did not receive the Activity of Daily Living (ADL) care for shaving, which was part of the grooming process, especially for a female resident.</p> <p>Record review of Task Record revealed Resident #43 had a bath on 9/9/24 at 8 PM.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #43's Admission Record revealed the facility admitted the resident on 12/18/2020. Diagnoses included Type 1 diabetes mellitus and arthritis.</p> <p>Record review of Resident #43's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had a mild cognitive impairment.</p> <p>Resident #151</p> <p>On 9/9/24 at 10:50 AM, an observation and interview with Resident #151 revealed fingernails were long (approximately one-half inch from nail bed) with a brown substance noted under nails. The resident stated she would love for her nails to be trimmed but no one had done it.</p> <p>On 9/10/24 at 4:15 PM, during an observation and interview with the DON and Resident #151, the resident stated she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail and nails were to be trimmed and cleaned to ensure skin was not scratched and to prevent infections and the facility failed to do this.</p> <p>Record review of Resident #151's Admission Record revealed the facility admitted the resident on 8/23/24. Diagnoses included Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Need for assistance with personal care.</p> <p>Record review of Resident #151's admission MDS with ARD of 8/30/24 revealed a BIMS score of 9 which indicated the resident was moderately impaired cognitively.</p> <p>Resident #59</p> <p>An observation and interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, I'm not going to lie on them or for them. I have not had a bath of any type since last Tuesday; They will wash my face, but that's it. He revealed he would love to be really cleaned up. This observation revealed the resident was a double above the knee amputee and stated he needed assistance with his baths.</p> <p>An interview on 9/10/2024 at 10:17 AM, with Certified Nurse Assistant (CNA) #1 confirmed that she was assigned to Resident #59, and he had told her he only gets a bath when she was on duty. She stated she knew that the resident complained to Licensed Practical Nurse (LPN) #1 last week about it, but was not sure what happened.</p> <p>In an interview on 9/10/2024 at 12:10 PM, with LPN #1, confirmed that Resident #59 had complained to her about not receiving a bath on 8/31/24, but she did not report it to anyone, that she just discussed it with the resident.</p> <p>Record review of documented baths for Resident #59 confirmed that the resident did not receive a bath on 8/31/2024. This documentation revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #59 on 11/14/2023 with a medical diagnosis of chronic venous insufficiency.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Quarterly MDS with an ARD of 7/24/2024 revealed, under section C, a BIMS summary score of 13, which indicated Resident #59 was cognitively intact and in Section GG that the resident needs assistance with Activities of Daily Living (ADL's).</p> <p>Resident #68</p> <p>An observation and interview on 9/9/2024 at 10:20 AM, with Resident #68 revealed, she was sitting in her wheelchair in her room. The resident explained that both Saturday (9/7) and Sunday (9/8) she rang her call light and told the aide who came in that she was wet and needed to be changed. She revealed on both days the aide turned the call light off, said she would be back, and left the room without ever coming back. She revealed, last night, her sister called the facility and spoke with the nurse to report that the aide never came back. The resident explained that the nurse and another aide later came to change her. She revealed, I sat in that urine for an hour.</p> <p>On 9/10/2024 at 8:50 AM, in an interview with the DON revealed she was aware of both incidents that happened over the weekend with Resident #68. She explained that she met with the resident and her son yesterday. She revealed the aide who cared for the resident on Saturday (9/7) had been terminated. The DON revealed she spoke with the aide, and the aide stated that she changed the resident after breakfast and that every time she went back into the resident's room, the resident was asleep. The aide reported that she did not wake the resident to check her or provide incontinent care. The DON revealed that she terminated the aide because this was her second occurrence of not making rounds and leaving the residents soiled. She explained that the resident had a different aide on Sunday (9/8). The DON revealed that she met with the aide, and the aide stated that she answered the call light, cut it off, and told the resident she would be back, but never went back. She revealed the resident called her sister, who then called the facility and reported the issue. The DON revealed that during that time the aide had gone to break, and the aide stated that she had changed the resident before supper. The DON revealed the aide was written up and counseled on answering the call lights and rendering the care when needed, as this was her first offense. The DON confirmed her expectations were for the aides to make rounds on the residents every two (2) hours and as required, and render the necessary care needed.</p> <p>An interview with Resident #68 on 9/10/2024 at 9:25 AM, revealed the aide assigned to her on Sunday (9/8) did not toilet or change her before supper. She explained that she waited until after supper and the trays were all picked up and pushed her call light to be changed. She stated the aide came in, turned the light off and said she would be back. The resident explained that after the aide did not return, she called her sister around 7:30 PM, who called the facility. She stated, They don't come check on me every 2 hours; They say they do, but they don't. She stated, They can't be lying on me because I have my mind.</p> <p>An interview with the DON on 9/10/2024 at 1:21 PM, confirmed staff did not provide the necessary care for Resident #68. She revealed her expectations were for staff to answer the call lights and render the care that the resident needs in a timely manner. She explained that the aides were to make rounds every 2 hours and as needed to ensure the residents were clean and dry and to prevent skin breakdown.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Certified Nurse Aide (CNA) #4 on 9/10/2024 at 3:20 PM, revealed she had been employed at the facility for eight (8) months and worked 3-11 shift. She revealed on Sunday (9/8) she was assigned to Resident #68. She revealed she had the split section which included her working the top section of A and B hall. CNA #4 revealed she was in the middle of cleaning up another resident on another hall at the time Resident #68's light went off. She explained that she had stepped out of the other resident's room to get some clean linen when she answered Resident #68's light, turned it off, and told the resident she would be back. She stated she forgot to go back.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #68 on 8/19/2024 with a medical diagnosis of Chronic Combined Systolic and Diastolic Heart Failure.</p> <p>Record review of the Admission MDS with an ARD of 8/26/2024 revealed, under section C, a BIMS score of 13, which indicated Resident #68 was cognitively intact.</p> <p>Resident #351</p> <p>On 9/9/2024 at 10:45 AM, observation of Resident #351 and interview with a family member revealed, he was sitting in a reclining wheelchair in his room. His eyes were open, and he was non-verbal. The resident was wearing a gray pair of jogger pants that were saturated through the groin area and in between the legs with urine. The family member revealed he was brought back from therapy like this, and nobody had been there since to check on him. The family member revealed the resident's bed was always wet with urine. She revealed the bed was soaked out this morning and had to be changed after they got him up. She stated, They say they are changing him every 2 hours, but they are not because I am here, and they do not enter the room. She explained that the resident was wetting out his clothes and the bed with urine through a brief. The family member revealed when he was in bed, she positioned a pillow under his stroke affected arm, and it even got soaked with urine. She reiterated, They are not changing him like they should be. She revealed she had been waiting on the resident's nurse to come back since 10:15 AM because she had some questions regarding the resident's fluid medication, but she had yet to come back.</p> <p>On 9/9/2024 at 10:51 AM, an interview with CNA #5 revealed she got Resident #351 up this morning, but she was unsure what time. She stated the resident had been to therapy, and she did not realize he was back. She revealed therapy did not come and let her know he was back or that he was wet. CNA #5 revealed she makes rounds every 2 hours to see if the residents need changing. She confirmed the resident's bed linen had to be changed because it was wet this morning.</p> <p>An interview with the DON on 9/10/2024 at 11:10 AM revealed, Resident #351 should be checked and changed every 2 hours and more if he needed it. She explained that he may be a heavy wetter and needed to be changed more frequently. The DON revealed if the resident was a heavy wetter, she could see that the resident could wet the bed. She revealed she was not aware of the family members' concerns regarding the resident's care, and stated those concerns were just brought to her attention yesterday.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #351 on 8/23/2024 with diagnoses including cerebral infarction.</p> <p>Resident #352</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/9/2024 at 10:58 AM an observation and interview with Resident #352 revealed, he was lying in bed. There was a foul odor around the resident. The resident revealed, after he ate breakfast and took his morning medicine, it was 2 hours before someone could come to clean him up and change him. He stated, They tell me they are working with somebody and will get to me when they can. He revealed the therapy man will even come to his room to take him to therapy, and he must tell him that he cannot go right now because he needs changing. The resident stated, He (the therapy man) wouldn't want to sit like that, so he should understand. The resident stated he was still waiting to be changed today.</p> <p>On 9/10/2024 at 11:50 AM, interview with the Physical Therapy Assistant (PTA) revealed, Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8:00-9:00 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the resident, but nine times out of ten he cannot find anybody. The PTA stated yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her, and she went to change the resident.</p> <p>An interview with the DON on 9/10/2024 at 2:52 PM, revealed she was not aware Resident #352 was not being changed in a timely manner. She stated that therapy had not reported anything to her. She revealed when an issue was brought to her attention, she would address it. The DON confirmed that the aides should be rounding on the residents every 2 hours and the residents should be changed in a timely manner.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #352 on 9/3/2024 with diagnoses that included Osteomyelitis of vertebra, thoracic region.</p> <p>Record review of the Admission MDS with an ARD of 8/13/2024 revealed under section C, a BIMS score of 15, which indicated Resident #352 was cognitively intact.</p> <p>44804</p> <p>47874</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>47874</p> <p>Based on observation, resident/family/staff interviews, and record review, the facility failed to ensure nursing staff provided the necessary resident care for six (6) of seven (7) residents reviewed for Activities of Daily Living (ADL) during the survey. Resident #43, #59, #68, #151, #351, #352</p> <p>Cross-Reference to F 677</p> <p>Findings include:</p> <p>Record review of a statement on letterhead dated 9/11/2024 and signed by the Executive Director revealed, (Proper name of facility) do not have a policy on staffing. We staff according to resident acuity.</p> <p>Resident #43</p> <p>During an interview and observation on 9/9/24 at 10:50 AM, Resident #43 revealed her preference was to have her facial hair removed by shaving, and she had asked staff to assist her with this, but they had not and facial hair was noted on resident's face.</p> <p>An interview and observation of Resident #43 on 9/10/24 at 11:50 AM, revealed facial hair on the chin and lower jaw area. She stated she had a shower yesterday afternoon, and she wanted her facial hair to be removed, but the staff did not do it.</p> <p>During an interview and observation in Resident #43's room on 9/10/24 at 12:05 PM, the resident informed the Director of Nursing (DON) that she wanted her facial hair shaved, but staff had not done this. The resident informed the DON she had a shower yesterday afternoon, but shaving was not done.</p> <p>Resident #59</p> <p>An observation and interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, I'm not going to lie on them or for them. I have not had a bath of any type since last Tuesday. They will wash my face, but that's it. He revealed he would love to be really cleaned up. This observation revealed the resident was a double above the knee amputee and stated he needed assistance with his baths.</p> <p>An interview on 9/10/2024 at 10:17 AM, with Certified Nurse Assistant (CNA) #1 confirmed that she was assigned to Resident #59, and he had told her he only gets a bath when she was on duty. She stated she knew that the resident complained to Licensed Practical Nurse (LPN) #1 last week about it, but was not sure what happened.</p> <p>An interview on 9/10/2024 at 12:10 PM, with LPN #1 confirmed that Resident #59 had complained to her about not receiving a bath on 8/31/24, but she did not report it to anyone. She stated that she just discussed it with the resident.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of documented baths for Resident #59 confirmed that the resident did not receive a bath on 8/31/2024. This documentation revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.</p> <p>Resident #68</p> <p>An observation and interview on 9/9/2024 at 10:20 AM, with Resident #68 revealed, she was sitting in her wheelchair in her room. The resident explained that both Saturday (9/7/24) and Sunday (9/8/24) she rang her call light and told the girl who came in that she was wet and needed to be changed. She revealed on both days the girl turned the call light off, said she would be back, and left the room without ever coming back. She revealed, last night, her sister called the facility and spoke with the nurse to report that the aide never came back. The resident explained that the nurse and another aide later came to change her. She revealed, I sat in that urine for an hour.</p> <p>An interview with the Director of Nursing (DON) on 9/10/2024 at 8:50 AM, revealed, she was aware of both incidents that happened over the weekend with Resident #68. She explained that she met with the resident and her son yesterday. She revealed the aide who cared for the resident on Saturday (9/7/24) had been terminated. The DON revealed she spoke with the aide, and the aide stated that she changed the resident after breakfast and that every time she went back into the resident's room, the resident was asleep. The aide reported that she did not wake the resident to check her or provide incontinent care. The DON revealed that she terminated the aide because this was her second occurrence of not making rounds and leaving the residents soiled. She explained that the resident had a different aide on Sunday (9/8/24). The DON revealed that she met with the aide, and the aide stated that she answered the call light, cut it off, and told the resident she would be back, but never went back. She revealed the resident called her sister, who then called the facility and reported the issue. The DON revealed that during that time the aide had gone to break, and the aide stated that she had changed the resident before supper. The DON revealed the aide was written up and counseled on answering the call lights and rendering the care when needed, as this was her first offense. The DON confirmed her expectations were for the aides to make rounds on the residents every 2 hours and as required and render the necessary care needed.</p> <p>An interview with Resident #68 on 9/10/2024 at 9:25 AM, revealed the aide assigned to her on Sunday (9/8/24) did not toilet or change her before supper. She explained that she waited until after supper and the trays were all picked up and pushed her call light to be changed. She stated the aide came in, turned the light off and said she would be back. The resident explained that after the aide did not return, she called her sister around 7:30 PM, who called the facility. She stated, They don't come check on me every 2 hours. They say they do, but they don't. She stated, They can't be lying on me because I have my mind.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Certified Nurse Aide (CNA) #4 on 9/10/2024 at 3:20 PM, revealed she had been employed at the facility for 8 months and worked 3-11 shift. She revealed on Sunday (9/8/24) she was assigned to Resident #68. She revealed they were short-staffed that day, and she had the split section, which included her working the top section of A and B hall. CNA #4 revealed she was in the middle of cleaning up another resident on another hall at the time Resident #68's light went off. She explained that she had stepped out of the other resident's room to get some clean linen when she answered Resident #68's light, turned it off, and told the resident she would be back. She stated she forgot to go back. CNA #4 revealed they work short-staffed a lot and stated that staffing was a big concern because things do not get done. She revealed the aides were responsible for vitals, showers, making rounds every 2 hours, toileting, passing out supper trays, assisting the residents who need help with eating, picking the trays back up, answering the call lights, passing out ice, and charting. She stated, It's a lot. I'm just one person and I do all I can do.</p> <p>Resident #151</p> <p>An observation and interview with Resident #151 on 9/9/24 at 10:50 AM, revealed fingernails were long (approximately one-half inch from nail bed) with a brown substance noted under the nails. The resident stated she would love for her nails to be trimmed, but no one had done it.</p> <p>During an observation and interview with the Director of Nursing (DON) and Resident #151 on 9/10/24 at 4:15 PM, the resident stated she wanted her nails to be trimmed. The DON confirmed Resident #151's nails were long with a brown substance under each nail. She stated nails were to be trimmed and cleaned to ensure the skin was not scratched and to prevent infections, and the facility failed to do this.</p> <p>Resident #351</p> <p>An observation on 9/9/2024 at 10:45 AM, revealed Resident #351 was sitting in a reclining wheelchair in his room. His eyes were open, and he was non-verbal. The resident was wearing a gray pair of jogger pants that were saturated through the groin area and in between the legs with urine. An interview with a family member, while in the room, revealed he was brought back from therapy like this, and nobody had been there since to check on him. The family member revealed the resident's bed was always wet with urine. She revealed the bed was soaked out this morning and had to be changed after they got him up. She stated, They say they are changing him every 2 hours, but they are not because I am here, and they do not enter the room. She explained that the resident was wetting out his clothes and the bed with urine through a brief. The family member revealed when he was in bed, she positioned a pillow under his stroke affected arm, and it even got soaked with urine. She reiterated, They are not changing him like they should be. She revealed she had been waiting on the resident's nurse to come back since 10:15 AM because she had some questions regarding the resident's fluid medication, but she had yet to come back.</p> <p>An interview with CNA #5 on 9/9/2024 at 10:51 AM, revealed she got Resident #351 up this morning, but she was unsure what time. She stated the resident had been to therapy and she did not realize he was back. She revealed therapy did not come and let her know he was back or that he was wet. CNA #5 confirmed the resident's bed linen had to be changed because it was wet this morning.</p> <p>Resident #352</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview with Resident #352 on 9/9/2024 at 10:58 AM, revealed he was lying in bed with a foul odor noted around the resident. The resident revealed, after he ate breakfast and took his morning medicine, it was 2 hours before someone could come to clean him up and change him. He stated, They tell me they are working with somebody and will get to me when they can. He revealed the therapy man will even come to his room to take him to therapy, and he must tell him that he cannot go right now because he needs changing. The resident stated, He (the therapy man) wouldn't want to sit like that, so he should understand. The resident stated he was still waiting to be changed today.</p> <p>An interview on 9/10/24 at 11:05 AM, with CNA #1 and #2 revealed they had been working at the facility for about 4 months and stated they work shorthanded a lot and usually just get one day a week off.</p> <p>An interview with the Physical Therapy Assistant (PTA) on 9/10/2024 at 11:50 AM, revealed Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8-9 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the resident, but nine times out of ten he cannot find anybody. The PTA stated like yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her. The nurse then went to change the resident.</p> <p>An interview with the Director of Nursing (DON) on 9/10/2024 at 3:12 PM, revealed they base their facility staffing needs on the acuity of the residents.</p> <p>Record review of a list provided by the facility revealed there were 18 residents who required assistance with meals.</p> <p>Record review of a list provided by the facility revealed there were 19 residents that requires the use of a total lift x 2 staff members for transfer.</p> <p>Record review of a list provided by the facility revealed there were 14 residents that requires the use of a sit-to-stand lift x 2 staff for transfers.</p> <p>Record review of a list provided by the facility revealed there were 16 residents that requires the assistance of 2 staff members for transfers.</p> <p>An interview with the Staff Development Nurse on 9/10/2024 at 3:40 PM, revealed the aides were responsible for ensuring the residents were clean and dry, answering call lights, making rounds, meals and providing showers which are split between 7-3 and 3-11 shifts. She revealed they do not have a shower team right now, but it was the goal. She revealed call ins were the main concern with staffing and explained that call ins were called to her or the DON. She revealed she then tries to get someone to fill the position but sometimes they are not able to get anyone. The Staff Development Nurse explained that sometimes the aides do not show up for a shift and do not call and then try to say they tried calling the facility, which leaves them in a bind. Furthermore, she explained they do have a high acuity of residents and stated any of the residents that use a lift of any kind must have 2 staff present for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Staff Development Nurse on 9/11/2024 at 9:30 AM, revealed On a good day, the aides are responsible for caring for 14-15 residents a piece. She explained that they work with 2 aides to each hall for all shifts, and sometimes extra when they can get someone. She revealed they are actively hiring for 4 nurse positions and 3 aides. She confirmed call ins were the biggest concern. She stated that she had to work as a med cart nurse on 3 PM-11 PM last night due to a call in, and revealed they were short-staffed. She explained that the 7 AM-3 PM shift was her most challenging shift to staff. She stated that the staff was just different now versus how they used to be and stated, They are more concerned about how much they are going to get paid. She explained that she tried to encourage the charge nurses on each hall to take charge of their hall and their CNA's, but that does not always happen. She stated, unfortunately, you sometimes must treat them like children and give them direction.</p> <p>An interview with CNA #7 on 9/11/2024 at 10:02 AM, revealed she has worked at the facility for 1 year and worked night shift but was working over today to fill an open position. She explained that on day shift they usually have about 7 showers to do, which did pull them away from the floor. She revealed they split them between the 2 aides on the hall and tried to cover each other's lights during that time.</p> <p>An interview on 9/11/24 at 11:10 AM, the DON revealed that she relies on the Charge Nurses and Unit Managers to direct their staff and follow-up to make sure the work is done. She admitted that does not always happen. She stated honestly sometimes you have to treat them like children, for instance the aides need to be told exactly what to do. She revealed she knows there have been issues but does not know the answer. She stated staff in healthcare is just different now, they are worried more about the money than the job. She revealed they do not even think of it as health care, instead just health services.</p> <p>An interview with the Administrator (ADM) with the DON in attendance, on 9/11/2024 at 11:16 AM, revealed she was not aware of any workload concerns from the staff or care concerns from the residents. She revealed we discuss this in resident council meetings and every morning in the stand-up meeting. She revealed the aides say they are short, but we are not. The ADM stated, We just have the wrong people in place. The ADM explained that they have a Registered Nurse (RN) Unit Manager for both units, and they also have a LPN which was a Charge Nurse on each hall. She confirmed they were supposed to be rounding on the residents to ensure the care was provided, and the resident's needs were met.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>44804</p> <p>Based on staff interview and record review, the facility failed to ensure that staff were trained on dementia care prior to caring for residents with dementia for one (1) of three (3) survey days.</p> <p>Findings Include:</p> <p>Record review of a typed statement on facility letterhead, dated September 11, 2024 and signed by the Executive Director revealed (Proper name of facility) do not have a policy on training staff or competency of staff.</p> <p>Record review of a typed statement on facility letterhead, dated September 11, 2024 and signed by the Executive Director revealed (Proper name of facility) have not implemented training on Dementia Care.</p> <p>An interview on 09/10/24 at 11:05 AM, with Certified Nurse Assistant (CNA) #1 and CNA #2 revealed they had been working at the facility for about 4 months and had not been trained on dementia care. CNA #1 stated that she did not know any special considerations regarding dealing with residents that have dementia and that she did not have any residents on her assigned B hall that had dementia.</p> <p>An interview on 09/10/24 at 11:48 AM, with the Staff Development Nurse confirmed that dementia care training is not included in the new hire orientation. She stated she has a video that she could let them watch, but she does not.</p> <p>An interview on 09/10/24 at 11:58 AM, with the Administrator confirmed that staff should be receiving dementia care training prior to caring for residents because we have a lot of residents with dementia. She stated that was a staff competency issue and they need to know how to deal and approach residents with dementia.</p> <p>Record review revealed the last two dementia care in-services were on 8/25/23 and 10/06/23.</p> <p>An interview on 09/10/24 at 12:42 PM with the Staff Development Nurse confirmed that CNA #1 and CNA #2 had not received any training on dementia care prior to starting work. She stated she had been doing staff development for about 5 years and it had never been included in the new hire orientation and training. She stated she understands now that it should have been included so that staff would know how to react and deal with residents and be able to recognize the signs. She confirmed that the last dementia care in-service was on 10/6/23.</p> <p>Record review of the New Hire Program revealed dementia care was not included.</p> <p>Record review of the Facility Assessment Tool dated July 22, 2024 revealed New Hire Training Topics-All Staff did not include dementia care listed as a required topic.</p> <p>Record review of the facility Resident Matrix revealed there were 16 current residents with a diagnosis of Dementia and/or Alzheimer's Disease and 2 resided on the B Hall.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>41878</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from unnecessary drug use as evidenced by no side effect monitoring for the use of psychotropic medications for three (3) of 64 residents receiving psychotropic medications. (Resident #44, #54 and #87)</p> <p>Findings include:</p> <p>Record review of the facility policy Behavior Management and Psycho-pharmacological Medication Monitoring Protocol, (K.1) with a History date of 3/18 revealed Policy: Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications .</p> <p>Record review of Resident #44's Order Summary Report with active orders as of 9/10/24 revealed orders dated 11/29/23 for Duloxetine 30 milligrams (mg) - give one capsule by mouth in the afternoon related to major depressive disorder (give along with the 60 mg to equal a 90 mg dose, Duloxetine 60 mg - give one tablet by mouth in the afternoon related to major depressive disorder (take along with the 30 mg to equal 90 mg dose). Quetiapine Fumarate tablet 25 mg - give 0.5 tablet by mouth at bedtime related to generalized anxiety disorder. Lorazepam 0.5 mg tablet - Give 0.5 tablet by mouth two times a day related to Generalized anxiety disorder. Divalproex Sodium Cap Delayed Release Sprinkle 125 mg - Give 2 capsules by mouth three times a day related to Generalized anxiety disorder.</p> <p>Record review of Resident #44's Admission Record revealed the facility admitted the resident on 11/29/23 with diagnoses that included Major depressive disorder, Generalized anxiety disorder, Primary insomnia and Restlessness and agitation.</p> <p>Record review of Resident #44's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/24, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.</p> <p>Resident #54</p> <p>During the record review of Resident #54's Order Summary Report with active orders as of 9/10/24 revealed orders dated 5/3/24 for Quetiapine Fumarate 100 milligrams (mg) tablet - give 1.5 tablet at bedtime related to Psychotic disorder with delusions, Memantine tablet 10 mg - Give one tablet every morning and at bedtime related to Unspecified dementia with psychotic disturbance, Divalproex Sodium delayed release 125 mg - Give one capsule orally two times a day related to Psychotic disorder with delusions, Donepezil Hydrochloride (HCl) 5 mg - Give one tablet orally at bedtime related to Unspecified dementia with psychotic disturbance, Mirtazapine 30 mg - Give one tablet at bedtime related to Major depressive disorder, Venlafaxine HCl tablet 75 mg (base equivalent) - Give 1.5 tablet one time a day related to Major depressive disorder (one and one half tablet to equal 112.5 mg), Buspirone HCl oral tablet 5 mg - give one tablet every morning and at bedtime related to Psychotic disorder with delusions due to known physiological condition.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #54's Admission Record revealed the facility admitted the resident on 7/20/23. Diagnoses included Dementia with psychotic disturbance, Alzheimer's disease, Psychotic disorder with delusions due to known physiological condition and Major depressive disorder.</p> <p>Record review of Resident #54's MDS with an ARD of 8/2/24 revealed a BIMS score of 3 which indicated severe cognitive impairment.</p> <p>Resident#87</p> <p>Record review of the Medication Review Report on or after date of 9/1/24 revealed an order dated 3/1/23 for Buspirone 10 MG: Give one tablet orally three times a day related to Generalized anxiety disorder, an order dated 3/1/23 for Fluoxetine 40 MG: Give one capsule orally one time a day related to Depressive episodes, an order dated 2/9/24 for Trazodone 100 MG tablet: Give one tablet orally at bedtime related to Insomnia, and an order dated 3/15/24 for Quetiapine Fumarate 25 MG: Give one tablet orally at bedtime related to Generalized anxiety.</p> <p>A continued review of the medical record for Resident # 87 revealed no monitoring for side effects of the use of psychotropic medications.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 87 on 3/01/23 with diagnoses that included Generalized anxiety disorder, Major depressive disorder, Other specified depressive episodes, and Insomnia.</p> <p>An interview with Registered Nurse (RN) #1 on 9/10/24 at 1:10 PM, revealed she did not routinely monitor or document side effects of psychotropic medication use. She stated if she noted any abnormal movement or other concern in her routine assessment or medication administration, she would document in progress note and notify the provider, but this was not done or documented routinely.</p> <p>During an interview on 9/10/24 at 1:40 PM, the Director of Nursing (DON) confirmed the facility did not monitor for side effects of psychotropic medication use. She acknowledged that monitoring for psychotropic medication side effects was important to ensure any adverse effect was noted quickly and responded to for appropriate care of the resident.</p> <p>In an interview with the Pharmacy Consultant on 9/10/24 at 3:05 PM, he revealed all residents on psychotropic medications should be monitored for side effects like over sedation and other adverse reactions that could indicate a resident may require a change in medication.</p> <p>47157</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>44804</p> <p>Based on observations, staff and resident interviews and record reviews, the facility failed to be administered in a way that allows it to use its resources effectively to ensure the wellbeing of its residents for three (3) of three (3) days of survey.</p> <p>Findings Include:</p> <p>This tag is cross referenced to F561, F584, F677, F725, F726, F758, F908, F924 & F947.</p> <p>Record review of a typed statement on facility letterhead dated September 11, 2024, and signed by the Executive Director revealed (Proper name of facility) do not have a policy on Administration or Administrative Staff. We have a job description for each employee position.</p> <p>Record review of the facilities Job Description with an effective date of 8/01/12 revealed Job Title: Executive Director . General Description .The Executive Director leads and directs the overall operation of the Facility in accordance with resident needs .so as to maintain quality care for the residents .Essential Duties 1. Works with the Facility management staff in planning all aspects of Facility's operations, including setting priorities and job assignments. Monitors each department's activities, communicates policies, evaluates performance, provides feedback and assists, coaches, and disciplines as needed .</p> <p>Record review of the facility Job Description: Job Title: Director of Nurses with an effective date of 01/2017 revealed General Description .Responsible for the overall management of resident care 24 hours a day, seven days per week .In the absence of the Executive Director, assumes responsibility for the Facility .</p> <p>Record review of the facility Job Description: Assistant Director of Nurses with an effective date of 01/2017 revealed General Description .Responsible for performing a variety of duties to provide quality nursing care to residents .</p> <p>F 561</p> <p>An interview on 09/10/24 at 11:00 AM, with the Dietary Manager revealed that the facility's coffee maker that was used to make the coffee for the residents had been broken for about two months. She stated that they had been boiling water on top of the stove and using a filter to make some coffee, but there was a delay in getting the coffee to the residents because it was a slow process. She confirmed she had complaints about the coffee machine being broken and understands the residents' frustration. She stated that the Administrator had known about it, and they tried to get someone to repair it, but they never came. She stated someone finally came yesterday and brought a coffee pot as a replacement and this one was working fine.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 09/10/24 at 11:24 AM, the Administrator confirmed that the coffee pot for the residents had been broken for a while, but she was thinking it had only been a month. She stated she thought someone had already been out to look at the coffee pot before yesterday. She stated that they had a back-up method for making coffee for the residents, but did not realize there was a delay in getting it out to the residents.</p> <p>F 584</p> <p>An observation of room D5 B on 9/9/24 at 10:20 AM, revealed a light gray fall protection floor mat that was a length of 72 inches by width of 24 inches on the left side of the bed covered in black and brown dried stains. A quarter size clump of a brown leaf tobacco product was observed on the floor next to the floor mat, with a dried brown ring around the tobacco.</p> <p>In an interview with the Director of Nursing (DON) on 9/9/24 at 3:10 PM, revealed the floor mats should be cleaned daily to prevent the spread of infections when staff step on the dirty fall mat.</p> <p>In an interview with the Assistant Director of Nursing/Infection Control Nurse on 9/10/24 at 10:44 AM, she revealed that the resident's fall mat should be cleaned and sanitized every day along with the room to reduce the risk for spread of infection.</p> <p>F 677</p> <p>Resident #43</p> <p>During an interview and observation in Resident #43's room on 9/10/24 at 12:05 PM, the resident informed the Director of Nursing (DON) that she wanted her facial hair shaved, but staff had not done this. The resident informed the DON she had a shower yesterday afternoon, but shaving was not done. The DON confirmed the resident, who required assistance with care, had facial hair present and did not receive the Activity of Daily Living (ADL) care for shaving, which was part of the grooming process, especially for a female resident.</p> <p>During an observation and interview with the Director of Nursing (DON) and Resident #151 on 9/10/24 at 4:15 PM, the resident revealed she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail and nails were to be trimmed and cleaned to ensure skin was not scratched and to prevent infections and the facility failed to do this.</p> <p>Resident #59</p> <p>An observation and interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, I'm not going to lie on them or for them. I have not had a bath of any type since last Tuesday. They will wash my face, but that's it. He revealed he would love to be really cleaned up.</p> <p>An interview on 9/10/2024 at 12:10 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #59 had complained to her about not receiving a bath on 8/31/24, but she did not report it to anyone.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of documented baths for Resident #59 confirmed that the resident did not receive a bath on 8/31/2024. This documentation revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.</p> <p>Resident #68</p> <p>An interview with the Director of Nursing (DON) on 9/10/2024 at 8:50 AM, revealed she was aware of both incidents that happened over the weekend with Resident #68 regarding not answering the call light and providing incontinent care timely. She revealed the aide who cared for the resident on Saturday (9/7/24) had been terminated. The DON revealed she spoke with the aide, and the aide stated that she changed the resident after breakfast and that every time she went back into the resident's room, the resident was asleep. The aide reported that she did not wake the resident to check her or provide incontinent care. The DON revealed that she terminated the aide because this was her second occurrence of not making rounds and leaving the residents soiled. She explained that the resident had a different aide on Sunday (9/8/24). The DON revealed that she met with that aide, and the aide stated that she answered the call light, cut it off, and told the resident she would be back, but never went back. She revealed The DON confirmed her expectations were for the aides to make rounds on the residents every 2 hours and as required, and render the necessary care needed.</p> <p>An interview with the Director of Nursing (DON) on 9/10/2024 at 1:21 PM, confirmed staff did not provide the necessary care for Resident #68. She revealed her expectations were for staff to answer the call lights and render the care that the resident needs in a timely manner. She explained that the aides were to make rounds every 2 hours and as needed to ensure the residents were clean and dry and to prevent skin breakdown.</p> <p>Resident #151</p> <p>During an observation and interview with the DON and Resident #151 on 9/10/24 at 4:15 PM, the resident revealed she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail and nails were to be trimmed and cleaned to ensure skin was not scratched and to prevent infections and the facility failed to do this.</p> <p>Resident #351</p> <p>An interview with the DON on 9/10/2024 at 11:10 AM, revealed Resident #351 should be checked and changed every 2 hours and more if he needed it. She explained that he may be a heavy wetter and needed to be changed more frequently. The DON revealed if the resident was a heavy wetter, she could see that the resident could wet the bed. She revealed she was not aware of the family members' concerns regarding the resident's care, and stated those concerns were just brought to her attention yesterday.</p> <p>Resident #352</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview with the Physical Therapy Assistant (PTA) on 9/10/2024 at 11:50 AM revealed, Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8-9 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the resident, but nine times out of ten he cannot find anybody. The PTA stated like yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her. She then went to change the resident. He confirmed that this caused a delay in therapy session because time starts when he knocks on the door.</p> <p>An interview with the DON on 9/10/2024 at 2:52 PM, revealed, she was not aware Resident #352 was not being changed in a timely manner. She stated that therapy had not reported anything to her. She revealed when an issue was brought to her attention, she would address it. The DON confirmed that the aides should be rounding on the residents every 2 hours and the residents should be changed in a timely manner.</p> <p>F 725</p> <p>An interview on 9/11/24 at 11:10 AM, with the DON revealed that she relies on the charge nurses and Unit Managers to direct their staff and follow-up to make sure the work is done. She admitted that does not always happen. She stated honestly sometimes you have to treat them like children, for instance the aides need to be told exactly what to do. She revealed she knows there have been issues but does not know the answer. She revealed that staff in healthcare today is just different now, they are worried more about the money than the job. She revealed they do not even think of it as health care, instead just health services.</p> <p>An interview with the Administrator (ADM) with the Director of Nursing (DON) in attendance, on 9/11/2024 at 11:16 AM, revealed she was not aware of any workload concerns from the staff or care concerns from the residents. She revealed we discuss this in resident council meetings and every morning in the stand-up meeting. She revealed the aides say they are short, but they are not. The ADM stated, We just have the wrong people in place. The ADM explained that they have a Registered Nurse (RN) Unit Manager for both units, and they also have an LPN which was a Charge Nurse on each hall. She confirmed they were supposed to be rounding on the residents to ensure the care was provided and the resident's needs are met.</p> <p>F 726</p> <p>An interview on 09/10/24 at 11:48 AM, with the Staff Development Nurse confirmed that dementia care training is not included in new hire orientation. She stated she has a video that she could let them watch, but she does not. She stated that staff just get in-serviced on dementia care when it is time for an in-service.</p> <p>An interview on 09/10/24 at 11:58 AM, with the Administrator revealed she was unaware that new staff were not receiving dementia care training prior to working. She stated that staff should be receiving dementia care training prior to caring for residents because we have a lot of residents with dementia. She stated that was a staff competency issue and they need to know how to deal and approach residents with dementia.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>F 908</p> <p>During an observation and interview with the Director of Nursing (DON) on 9/10/24 at 1:00 PM, she confirmed that Resident #84's wheelchair arms needed to be replaced to prevent skin injury. She revealed that they had a system in place for any needed repairs to be noted in so areas of concern could be corrected, but this was overlooked and not put into their system. She confirmed the facility failed to maintain Resident #84's wheelchair in safe and good repair, which could cause an injury to the resident's skin.</p> <p>F 924</p> <p>An interview and observation on 9/9/24 at 12:00 PM with the Administrator confirmed that the hand rails on the resident halls had been loose for a while. She admitted that they had been talking about replacing them, but she wanted to get the floor replaced first. She stated that the hand rails were PVC pipes, and they had put them up. She stated she knew one of the residents on the B Hall pulled on them a lot but had not had an accident. She revealed that she had talked with a company about getting it fixed, but that was back in May, and she had not got that approved from corporate yet. She admitted that the lose handrails could be a safety issue for the residents.</p> <p>F 947</p> <p>An interview and observation on 9/9/24 at 12:00 PM with the Administrator confirmed that the hand rails on the resident halls had been loose for a while. She admitted that they had been talking about replacing them, but she wanted to get the floor replaced first. She stated that the hand rails were PVC (Polyvinyl Chloride) pipes, and they had put them up. She stated she knew one of the residents on the B Hall pulled on them a lot but had not had an accident. She revealed that she had talked with a company about getting it fixed, but that was back in May, and she had not got that approved from corporate yet. She admitted that the lose handrails could be a safety issue for the residents.</p> <p>An interview on 09/11/24 at 12:52 PM, with the Administrator and the DON confirmed there is issues, but they are not sure if it is a breakdown in communication or follow up. The Administrator revealed they have been working on Survey Readiness since their last survey in 5/2023 and part of that was putting quality measures such as care under a Performance Improvement Plan (PIP). She stated that has included their administrative nurses and Unit Managers being assigned certain rooms and making rounds on those residents. She revealed that during those rounds they are supposed to be looking for issues such as needed care, dirty wheelchairs, facial hair, etc. She admitted there had been no real issues found and admits that is really impossible. The Administrator stated that there had been no changes to their polices or procedures based on the results of the rounds. They both admitted that when they do find something that needs to be fixed then they fix it, but never get to the root cause. The Administrator added that she has seen residents in the same clothes for days or have food on their clothes and has told the administrative staff and Unit Managers that if she sees these things she knows they do. The DON added that the administrative staff have to document their round results and turn them in, but the Unit Managers do not. She stated they verbally report if there are any issues. The DON admitted she thinks the problem is there is no accountability. They both agreed that they are accountable and should follow up as oversight to make sure the rounds are correct and being done and that care is being provided.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>44804</p> <p>Based on observations, staff and resident interviews, record review and facility policy review, the facilities Quality Assessment Performance Improvement (QAPI)/ Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place. This failure resulted in four recited deficiencies that was originally cited on the 5/18/23 recertification survey. The recited deficiencies were in the areas of failing to implement an Activities of Daily Living (ADL) care plan, assist residents with ADL's, monitor for side effects of psychotropic medications and place an infectious resident in contact isolation. The continued failures during 2 recertification's shows a pattern of the facilities inability to sustain an effective Quality Assurance Program.</p> <p>Findings Include:</p> <p>This tag is cross referenced to: F656, F677, F758 and F880.</p> <p>Review of the facility policy titled, Quality Improvement Program with a revision date of 10/2022 revealed under the Policy .The Quality Improvement Committee will assess and monitor the quality of services provided to the residents in the facility in order to identify potential problems and/or opportunities for improvement. The committee will implement and systemically evaluate programs and processes to identify problems in order to proactively improve health care delivery.</p> <p>During the recertification survey on 5/18/23 the facility was cited for F656, F677, F758, and F880.</p> <p>During the recertification and complaint survey on 9/9/24, the facility was cited for deficiencies that included repeat deficiencies of F656, for failure to implement a care plan regarding ADL's. F677 for failure to bath, shave and provide nail care for a total of 6 out of 7 residents investigated for ADL's. F758 for failing to monitor for side effects of psychotropic medications and F880 for failing to place a resident with an infectious disease in contact isolation.</p> <p>An interview on 9/11/24 at 11:10 AM, with the Director of Nurses (DON) revealed that she relies on the charge nurses and Unit Managers to direct their staff and follow up to make sure the work is done. She admitted that does not always happen. She revealed she knows there have been issues, but does not know the answer. She stated staff in healthcare is just different now, they are worried more about the money than the job.</p> <p>An interview and record review on 09/11/24 at 11:53 AM, with the Administrator revealed the facility has a QAPI/QAA meeting with the medical director and other interdisciplinary team members monthly. She stated they have not addressed staffing concerns, ADL care or care plans during the meetings.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview on 09/11/24 at 12:52 PM, with the Administrator and the DON confirmed there is an issue, but they are not sure if it is a breakdown in communication or follow up. The Administrator revealed they have been working on Survey Readiness since their last survey in 5/2023 and part of that was putting quality measures such as care under a Performance Improvement Plan (PIP). She stated that has included their administrative nurses and Unit Managers being assigned certain rooms and making rounds on those residents. She revealed that during those rounds they are supposed to be looking for issues such as needed care, dirty wheelchairs, facial hair, etc. She admitted there had been no real issues found and admits that its impossible for things to be perfect. The Administrator stated that there had been no changes to their polices or procedures based on the results of the rounds. They both admitted that when they do find something that needs to be fixed then they fix it, but do not get to the root cause. The Administrator added that she has seen residents in the same clothes for days or have food on their clothes and has told the administrative staff and Unit Managers that if she sees these things she knows they do. The DON added that the administrative staff have to document their round results and turn them in, but the Unit Managers do not. She stated they verbally report if there are any issues. The DON admitted she thinks the problem is there is no accountability. They both agreed that they are accountable and should follow up as oversight to make sure the rounds are correct and being done.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47157</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, resident and staff interview, record review, and facility review the facility failed to help prevent the transmission of infections when a resident returned from the hospital with a treatment for Clostridium Difficile Colitis (C-Diff) infection was not placed on contact isolation precautions for one (1) of 14 residents being treated for an infection. Resident #83</p> <p>Findings include:</p> <p>A review of Centers for Disease Control (CDC) document revealed Contact Precautions: Contact precautions are intended to prevent transmission of infectious agents, which are spread by direct or indirect contact with the patient or the patient's environment.(Example: C. Difficile) . C-diff is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon).Key Points: Most cases of C. Diff occur when you have been taking antibiotics or not long after you have finished .</p> <p>A review of the facility policy titled, Contact Precautions, revealed Policy: Contact precautions are a transmission-based precaution that will be utilized to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.</p> <p>In an interview with Resident # 83 on 9/9/24 at 10:00 AM, he revealed he had just returned from the hospital the day before with bad diarrhea. He stated the diarrhea was C-Diff. Observation of the resident's room revealed there were no isolation barrels in the room. There was no signage on the resident's door alerting the staff that the resident was on contact precautions.</p> <p>A review of the diagnosis information on the Admission Record for Resident #83 revealed on 8/30/24 he received a diagnosis of long-term use of antibiotics.</p> <p>A review of the Order Details revealed a physician's order for Resident # 83 dated 9/8/24 Fidaxomicin Oral Table 200 MG(milligram) Give 1(one) tablet by mouth every morning and at bedtime for C-Diff until 9/13/24.</p> <p>Review of hospital lab values for Resident #83 dated 9/3/24 revealed C. Difficile results was positive.</p> <p>In an interview with Licensed Practical Nurse (LPN) #2 on 9/9/24 at 1:20 PM, she revealed Resident #83 was not on contact precautions for C-Diff. She stated she asked the night nurse if the resident was supposed to be on isolation because he was on medication for C-diff, and the nurse told her no because he was treated in the hospital. LPN #2 stated she should have questioned this further.</p> <p>In an interview with the Director of Nursing on 9/9/24 at 1:50 PM, she revealed that Resident #83 did come back from the hospital with orders to treat C-Diff and confirmed staff should have placed him on contact isolation to reduce the risk of infection transmission.</p> <p>In an interview with Assistant Director of Nursing/Infection Control nurse on 9/10/24 at 11:38 AM, she confirmed Resident #83 should have been placed on contact isolation when he returned from the hospital the evening of 9/8/24 to reduce the spread of the infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Admission Record revealed the facility admitted Resident #83 on 6/09/23 with a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/24 revealed a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>41878</p> <p>Based on observation, staff and resident interview, and record review, the facility failed to ensure a wheelchair was in good, safe condition for one (1) of 21 sampled residents' wheelchairs. Resident #84</p> <p>Findings include:</p> <p>Record review of facility letterhead dated and signed by the Administrator on 9/11/24, revealed, (Proper name of facility) do not have a maintenance equipment repair policy.</p> <p>During an interview and observation on 9/9/24 at 11:20 AM, Resident #84's wheelchair was noted to have both arm rests with foam exposed between the cracked protective covering which covered all the left arm rest and was approximately four inches by one inch area on right arm rest. Resident #84 stated it had been that way for a while and those areas are rough to touch.</p> <p>During an observation and interview with the Director of Nursing (DON) on 9/10/24 at 1:00 PM, she confirmed that Resident #84's wheelchair arms needed to be replaced to prevent skin injury. She stated they had a system in place for any needed repairs to be noted in so areas of concern could be corrected, but this was overlooked and not put into their system. She confirmed the facility failed to maintain Resident #84's wheelchair in safe and good repair, which could cause an injury to the resident's skin.</p> <p>Record review of Resident #84's Admission Record revealed the facility admitted the resident initially on 9/26/23 with the most recent admission of 2/16/24 with diagnoses included Muscle wasting and atrophy, Muscle weakness and Cerebral infarction.</p> <p>Record review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p>

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>44804</p> <p>Based on observation, staff interview and facility letterhead review, the facility failed to ensure the handrails on the resident's halls were permanently affixed to the wall for four (4) of 4 hallways.</p> <p>Findings Include:</p> <p>Record review of a typed statement on facility letterhead, dated September 11, 2024, and signed by the Executive Director revealed the (Proper name of facility) do not have a policy on facility repairs.</p> <p>An observation on 09/09/24 at 11:49 AM, of all resident halls revealed multiple loose hand rails with the ends of the hand rails not being permanently affixed to the walls on all four halls of the facility.</p> <p>An interview and observation on 9/9/24 at 12:00 PM with the Administrator confirmed that the hand rails on the resident halls had been loose for a while. She admitted that they had been talking about replacing them, but she wanted to get the floor replaced first. She stated that the handrails were PVC (polyvinyl chloride) pipes, and they had put them up. She stated she knew one of the residents on the B Hall pulled on them a lot but had not had an accident. She revealed that she had talked with a company about getting it fixed, but that was back in May, and she had not got that approved from corporate yet. She admitted that the lose handrails could be a safety issue for the residents.</p> <p>Record review revealed that there was communication from (proper name of business) in 5/10/2024 regarding options for fixing the broken handrails in the facility.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>44804</p> <p>Based on staff interview and record review, the facility failed to ensure that new hire staff were trained on dementia care prior to caring for residents with dementia for one (1) of three (3) survey days.</p> <p>Findings Include:</p> <p>This tag is cross referenced to F 726, Competent Staff</p> <p>Record review of a typed statement on facility letterhead, dated September 11, 2024 and signed by the Executive Director revealed (Proper name of facility) do not have a policy on training staff or competency of staff.</p> <p>An interview on 09/10/24 at 11:05 AM, with Certified Nurse Assistant (CNA) #1 and CNA #2 revealed they both had been working at the facility for about 4 months and had not been trained on dementia care. CNA #1 stated that she did not know any special considerations regarding dealing with residents that have dementia and that she did not have any residents on her assigned B hall that had a diagnosis of dementia.</p> <p>An interview on 09/10/24 at 11:48 AM, with the Staff Development Nurse confirmed that dementia care training is not included in new hire orientation. She stated she has a video that she could let them watch, but she does not.</p> <p>An interview on 09/10/24 at 11:58 AM, with the Administrator confirmed that staff should be receiving dementia care training prior to caring for residents because we have a lot of residents with dementia. She stated that was a staff competency issue and they need to know how to deal and approach residents with dementia.</p> <p>An interview on 09/10/24 at 12:42 PM, with the Staff Development Nurse confirmed that she had been doing staff development for about 5 years and it had never been included in the new hire orientation and training. She stated she understands now that it should have been included so that staff would know how to react and deal with residents and be able to recognize the signs.</p> <p>Record review of the New Hire Program revealed dementia care was not include.</p> <p>Record review of the Facility Assessment Tool dated July 22, 2024 revealed New Hire Training Topics-All Staff did not include dementia care listed as a required topic.</p> <p>Record review of the facility Resident Matrix revealed there were 16 current residents with a diagnosis of Dementia and/or Alzheimer's Disease and 2 were on the B Hall.</p>		