

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/11/2025
NAME OF PROVIDER OR SUPPLIER Tupelo Community Care 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)		
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to implement a fall care plan for Resident # 3 and failed to implement a fluid restriction care plan for Resident #87 for two (2) of 23 care plans reviewed. Findings Include: Review of a facility policy titled, Goals and Objectives, Care Plans, last revised September 2013, revealed the policy statement indicated that care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. An observation conducted on 12/10/25 at 8:30 AM revealed Resident #3 in bed with three-quarter length side rails raised on both sides of the bed. Record review of a care plan titled, I am at high risk for falls related to impaired mobility and unawareness of safety precautions, initiated 9/5/24 and last revised 2/28/25, revealed interventions included use of three-quarter length side rails as enablers to assist with turning and repositioning while in bed, with instructions to release and reposition every two hours and as needed. Record review of an accident report dated 10/29/25 revealed staff heard yelling from down the hall. Upon entering the room, staff observed Resident #3 lying under the bedside table beside the bed. The resident's right leg was wrapped in a blanket, skin tears were noted to both elbows, and the resident complained of right hip pain. The resident stated, Yeah, I think it's broke, and further stated he rolled out of bed during sleep. Record review of Emergency Department records dated 10/29/25 revealed Resident #3 was diagnosed with a closed comminuted intertrochanteric fracture of the proximal end of the right femur. On 12/10/25 at 9:00 AM an interview with Resident #3 revealed he confirmed experiencing a fall in October when he rolled out of bed during the night because his side rail was not raised. On 12/10/25 at 10:10 AM a phone interview with Certified Nurse Assistant (CNA) #1 revealed she confirmed the left side rail was not raised when she entered Resident #3's room following the fall in October 2025. On 12/10/25 at 9:11 AM an interview with the Director of Nursing revealed that, upon investigation of Resident #3's fall from bed on 10/29/25, it was her understanding that the resident's side rail was not in the raised position at the time of the fall and it should have been. Review of the fall care plan with the Clinical Minimum Data Set (MDS) Nurse on 12/10/25 at 11:00 AM (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Actual harm Residents Affected - Few	revealed she confirmed the fall care plan was not implemented when Resident #3's side rail was not raised at the time of the fall. She further stated the resident was to have three-quarter length side rails bilaterally to assist with turning and repositioning while in bed. Record review of the admission Record revealed Resident #3 was admitted on [DATE] with diagnoses including acquired absence of the left leg above the knee and other reduced mobility. Record review of the Brief Interview for Mental Status (BIMS) score dated 11/8/25 revealed a score of 9, indicating the resident was moderately cognitively impaired. Resident #87 Review of Resident #87's Care Plan Report revealed under, Focus: I am at risk for complications d/t (due/to) renal dialysis with fluid restrictions r/t (related to) renal failure. Further revealed under, Interventions/Task: 900 CC (cubic centimeter) fluid restriction- breakfast-200 lunch -200 dinner- 200 medications & 200 snacks -100. Record review of Resident #87's December 2025 Medication Administration Record (MAR) revealed an order dated 7/16/25, Record fluid intake in 24 hours. 900 cc (cubic centimeter) fluid restriction & Breakfast 200, Lunch 200, Dinner 200, Medications 200, Snacks 100. Review revealed there was no documentation of fluid intake amounts recorded, and the MAR was only initialed by the nurse. Record review of Resident #87's December 2025 Flowsheet revealed there was no evidence that fluid intake was monitored or documented. On 12/10/25 at 11:32 AM, an interview with the Director of Nursing (DON) revealed fluid restrictions were to be tracked on the MAR and totaled at the end of each shift and the DON confirmed this was not done for Resident #87. An interview with the Minimum Data Set (MDS) Nurse on 12/11/25 at 8:15 AM revealed the purpose of the care plan was so that staff knew what care to provide. She confirmed the care plan was not followed for Resident #87 since staff were not tracking and documenting fluid intake. Record review of the admission Record revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the MDS with an ARD of 11/02/25 revealed under Section C, a BIMS summary score of 15, indicating Resident #87 was cognitively intact.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and record review, the facility failed to ensure adequate accident prevention for one (1) of five (5) residents reviewed for accident hazards (Resident #3). The facility failed to ensure the resident's ordered three-quarter length side rail was maintained in the raised position while the resident was in bed, resulting in the resident rolling out of bed and sustaining a fracture. Findings Include: Review of a statement on facility letterhead revealed that Proper Name Care Center did not have a specific policy pertaining to accident prevention. An observation conducted on 12/10/25 at 8:30 AM revealed Resident #3 in bed with three-quarter length side rails raised on both sides of the bed. Review of the Medication Review Report dated 1/13/25 revealed an order for three-quarter length side rails to be used as enablers to assist with turning and repositioning while in bed, with instructions to release and reposition every two hours and as needed. Review of an accident report dated 10/29/25 at 01:00 AM revealed that staff heard yelling from down the hall. Upon entering the room, staff observed Resident #3 lying under the bedside table beside the bed. The resident's right leg was wrapped in a blanket, skin tears were noted to both elbows, and the resident complained of right hip pain. The resident stated, Yeah, I think it's broke, and further stated he rolled out of bed during sleep. Review of Emergency Department records dated 10/29/25 revealed Resident #3 was diagnosed with a closed comminuted intertrochanteric fracture of the proximal end of the right femur. An interview with Resident #3 on 12/10/25 at 9:00 AM revealed he confirmed experiencing a fall in October when he rolled out of bed during the night because his side rail was not raised. He stated he uses the side rails to assist with turning and repositioning while in bed because he is an amputee. When asked why the side rail was not raised, he stated he did not know who had lowered it, but when he rolled over, it would have prevented him from falling in the floor if it had been up. A phone interview with Certified Nurse Assistant (CNA) #1 on 12/10/25 at 10:10 AM revealed she responded to the fall after hearing the resident yelling. She stated that upon entering the room, Resident #3 was lying on the floor on the left side of the bed, and the left side rail was not raised. An interview with the Director of Nursing on 12/10/25 at 9:11 AM revealed that, upon investigation of Resident #3's fall on 10/29/25, it was her understanding that the side rail was not in the raised position at the time of the fall. She stated the resident's bed was equipped with three-quarter length side rails on both sides, which were utilized to assist with turning and repositioning while in bed and should have been raised to prevent him from rolling out of the bed. She further confirmed that the side rail not being raised contributed to the resident's fall resulting in injury and fracture. An observation conducted on 12/10/25 at 2:37 PM with CNA #2 revealed the lever used to lower the left side rail was located at the end of the side rail near the foot of the bed. CNA #2 stated Resident #3 would not be physically able to reach the lever to lower the side rail. She further stated the resident does not attempt to get up without assistance and uses the side rails to assist with turning and repositioning since he is an amputee. Record review of the admission Record revealed Resident #3 was admitted on [DATE] with diagnoses including acquired absence of the left leg above the knee and other reduced mobility. Record review of the Brief Interview for Mental Status (BIMS) dated 11/8/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure resident privacy was maintained during medication administration for a resident with a gastrostomy tube for one (1) of six (6) care opportunities observed. Resident #16 Findings Include: Review of the facility policy titled Dignity with a revision date of 2/21 revealed under, Policy Interpretation and Implementation: . 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. An observation during medication pass on 12/10/2025 at 8:15 AM with Licensed Practical Nurse (LPN) #3 revealed she administered medications to Resident #16 via a gastrostomy tube while the room blind was half open, allowing the resident to be visible from the back parking lot and compromising the resident's bodily privacy. An interview with LPN #3 on 12/10/25 at 8:32 AM confirmed the window blind was left open while administering medications to Resident #16 and revealed this was a privacy concern for the resident as his stomach and tube were visible to the people outside the window. An interview with the Director of Nursing (DON) on 12/10/25 at 10:48 AM revealed that residents were expected to be provided privacy during care and confirmed this was a dignity concern. Record review revealed the facility admitted Resident #16 on 6/07/24 with medical diagnoses including Unspecified Sequelae of Cerebral Infarction and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 12, indicating Resident #16 was moderately cognitively impaired.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, record review, and facility policy review, each resident had the right to determine their end-of-life care and the facility failed to ensure the desired code status of the resident was reflected in the documentation for one (1) of 23 sample residents reviewed. Resident #10 Findings include: Record review of the facility policy titled, Advance Directives, undated, revealed, It is the policy of the facility to respect the resident's right of self-directed care including the right to issue Advance Directives on health care, to refuse or accept treatment, to make informed decisions, and/or appoint a health care agent to make decision on the behalf of the resident when the resident lacks the capacity to do so. 1. Each competent adult has the right to control his or her own health care decisions. Record review of facility policy titled, Resident Rights dated [DATE], revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . self-determination. Record review of Resident #10's Consent for Cardiopulmonary Resuscitation, undated, revealed, I understand that CPR (Cardiopulmonary Resuscitation) constitutes an extraordinary measure and SHOULD NOT be done on this resident. This was signed by the resident's representative. Record review of Resident #10's Do Not Resuscitate consent revealed the document was undated and signed by the resident's representative and the physician and indicated Resuscitation would be medically futile. Record review of Resident #10's electronic Order Listing Report revealed an order dated [DATE] for a full code. Record review of Resident #10's Physician Telephone Order dated [DATE] revealed, Patient is a full code. During an interview on [DATE] at 1:40 PM, the Director of Nursing (DON) revealed each resident had the right to choose their end-of-life care and this choice was required to be properly documented to ensure the resident's desired end-of-life care would be honored. She acknowledged the physician's orders indicated a full code status. She acknowledged the Consent for Cardiopulmonary Resuscitation (CPR) signed by the resident's representative indicated that CPR should not be done and the Do Not Resuscitate form was undated and signed by the resident's representative and the physician revealed Resuscitation would be medically futile. She acknowledged the documentation should reflect the resident's wishes for their end-of-life care and inaccurate documentation could lead to the resident's desires not being honored. She confirmed the facility failed to ensure the resident signed the consent for end-of-life care and failed to ensure the accuracy of the documentation for Resident #10's end-of-life care, which had the potential for the resident's desire to not be honored. An interview with Resident #10 on [DATE] at 3:05 PM, revealed she desired a full code status and was capable of signing her documents for this. An interview with the Administrator on [DATE] at 2:00 PM revealed each resident had the right to choose their end-of-life care and the documentation should be accurate and reflect the resident's wishes. She acknowledged the undated Consent for Cardiopulmonary Resuscitation signed by the resident's representative indicated CPR should not be done on this resident and the Do Not Resuscitate (DNR) consent, undated and signed by the resident's representative and the physician indicated a DNR status. She acknowledged the written order dated [DATE] and the electronic order dated [DATE] both indicated a full code status. She confirmed the facility failed to accurately document the resident's desire for end-of-life care which could have led to the resident's wishes not being honored. Record review of Resident #10's admission Record revealed the facility admitted resident originally on [DATE] with the most recent admission date of [DATE]. Diagnoses included Type 1 Diabetes Mellitus. Record review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review, staff interview, and facility policy review, the facility failed to accurately complete section K of the Minimum Data Set (MDS) for one (1) of 23 minimum data sets reviewed. Resident #100. Findings Include: Review of the facility policy titled Certifying Accuracy of the Resident Assessment undated, revealed under, Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. Record review of the Weights and Vitals Summary for Resident #100 revealed the following documented weights: 10/08/25 252 pounds 10/28/25 252 pounds 11/03/25 249.6 pounds 11/13/25 230.8 pounds 11/18/25 230.7 pounds Record review revealed Resident #100 has a significant weight loss of 21 pounds and -8.3% (percent) in 1 month. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed under section K0300, Resident #100 did not have a weight loss of 5 % (percent) or more in the last month, which was inaccurate. An interview with the MDS Nurse on 12/11/25 at 7:58 AM revealed she was responsible for completing section K of the MDS. She confirmed she made an error on Resident #100's MDS and stated weight loss should have been coded. Record review of the Transfer/Discharge Report revealed the facility admitted Resident #100 on 7/12/21 with medical diagnosis that included Chronic Combined Systolic and Diastolic Heart Failure. Record review of the Progress Notes for Resident #100 dated 11/20/25, revealed a Brief Interview for Mental Status (BIMS) Evaluation was not conducted due to resident is rarely/never understood. Record review of the admission Record revealed the facility admitted Resident #100 on 7/12/21 with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure fluid intake was managed, tracked, and documented in accordance with a physician ordered fluid restriction for a resident receiving dialysis for one (1) of six (6) resident reviewed for fluid restrictions. Resident #87 Findings Include: Review of the facility policy titled Encouraging and Restricting Fluids revised 10/10 revealed under, Purpose: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. The policy further revealed under, Steps in the Procedure: . 5. Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid in MLs (milliliters). Record review of Resident #87's December 2025 Medication Administration Record (MAR) revealed an order dated 7/16/25, Record fluid intake in 24 hours. 900 cc (cubic centimeter) fluid restriction - Breakfast 200, Lunch 200, Dinner 200, Medications 200, Snacks 100. Review revealed there was no documentation of fluid intake amounts recorded, and the MAR was only initialed by the nurse. Record review of Resident #87's December 2025 Flowsheet revealed there was no evidence that fluid intake was monitored or documented. Record review of Resident #87's December 2025 MAR revealed an order dated 8/03/24, Nepro/Carb Steady Oral Liquid (Nutritional Supplement) give 8 ounces by mouth two times a day for End Stage Renal Disease (ESRD). Record review of Resident #87's breakfast meal tray ticket dated 12/09/25 revealed under, Notes: Add Nepro to all trays. The tray ticket further revealed under, Beverages: Fluid Restriction: 4 ounces (OZ) Apple juice - 1 cup, Water - 1 cup. An observation on 12/09/25 at 8:06 AM revealed Resident #87 received her breakfast meal in her room which included two pieces of bacon, scrambled eggs, toast, 240 milliliters (ML) of water, and 120 ML of apple juice, totaling 360 ML of fluid at one meal, excluding the Nepro supplement. An interview with the Director of Nursing (DON) on 12/10/25 at 11:32 AM revealed fluid restrictions were to be tracked on the MAR and totaled at the end of each shift. The DON confirmed this had not been done for Resident #87 and stated the resident could be receiving too much fluid, which could contribute to fluid volume overload. She further confirmed there was inconsistency with the Nepro supplement and stated this would place the resident over her fluid restriction and should have been clarified. An interview with the Registered Dietitian (RD) on 12/10/25 at 11:52 AM revealed Resident #87 was receiving Nepro twice daily; however, she spoke with the dialysis RD in September, who suggested increasing the Nepro to three times daily. The RD confirmed she had not calculated the Nepro into the resident's daily fluid allowance. She further confirmed she was aware the resident's fluid intake was not being documented or totaled at the end of the shift but did not report this to the nursing department. She acknowledged this failure could cause the resident to develop fluid volume overload. Record review of the admission Record revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 11/02/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #87 was cognitively intact.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, resident and staff interview, and record review, the facility failed to ensure meals were served in accordance with a resident's physician-ordered nutritional requirements for one (1) of four (4) residents reviewed for dining. Resident #87 Findings Include: The facility provided a statement on letterhead that read, (Proper name of the facility) does not have a specific policy on therapeutic diet. During an observation on 12/09/25 at 8:06 AM, Resident #87 was observed sitting up in her wheelchair in her room with her breakfast tray in front of her untouched. The resident had 2 pieces of bacon, scrambled eggs, toast, water, and apple juice. Review of the meal ticket dated 12/09/25 revealed, Supplements: Nepro - 1 carton and under Notes; Add Nepro to all trays. The Nepro supplement was not on the meal tray. Resident #87 stated she only received it sometimes. An observation and interview with Licensed Practical Nurse (LPN) #1 on 12/09/25 at 8:12 AM confirmed Resident #87 did not receive the Nepro supplement as ordered on the meal ticket. LPN #1 stated the meal provided should match the meal ticket and acknowledged the resident would not receive the necessary nutrients if supplements were omitted. An interview with the Dietary Manager (DM) on 12/09/25 at 3:26 PM revealed she was made aware that Resident #87 did not receive Nepro with her breakfast meal. She stated it was the dietary drink aide's responsibility to read the meal cards and provide the necessary supplements on the meal tray. She described the incident as a human mistake and acknowledged Resident #87 would not get the necessary nutrients. Record review of the admission Record revealed the facility admitted Resident #87 on 2/01/22 with medical diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 11/02/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #87 was cognitively intact.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interview, record review, and facility policy review, the facility failed to clean and disinfect a multi-use glucometer according to the manufacturer's instructions and the required wet contact time for one (1) of two (2) glucometers observed. Resident #16 Findings Include: Review of the facility policy titled Assure Prism Multi Blood Glucose Monitor System: Use, Cleaning and Controls Policy undated, revealed under, Cleaning and Disinfecting the Assure Prism Multi Blood Glucose Monitoring System: 1. Follow standard precautions and the manufacture's disinfection procedures to clean and disinfect the meter. On 12/10/25 at 8:15 AM, an observation of Licensed Practical Nurse (LPN) #3 revealed she completed a blood glucose check for Resident #16 and then cleaned the glucometer using Sani-cloth germicidal wipes by swiping over the front and back of the machine three times for a total of 30 seconds. LPN #3 explained this was how she had been trained to clean the glucometer and stated this was the method their facility policy instructed them to use. LPN #3 was not aware of the wet contact time required on the back of the Sani-cloth container. She acknowledged that if the machine was not cleaned appropriately, it could spread germs to other residents because the glucometer was used on multiple residents. Record review of the manufacturer's instructions Arkway Technical Brief Cleaning and Disinfecting the Assure Prism multi-Blood Glucose Monitoring System (BGMS) revealed Super Sani-Cloth(R) Germicidal Disposable Wipe was listed for use in cleaning and disinfecting the meter. Further instruction revealed, Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Record review of the Super Sani-cloth Germicidal Disposable Wipes revealed, unfold wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. An interview with the Director of Nursing (DON) on 12/10/25 at 10:48 AM revealed the staff recently attended training and were taught to swipe over the glucometer with Sani-cloth wipes three times on the front and back. The DON explained she was aware of the required wet contact time on the Sani-cloth wipes and confirmed that improper glucometer cleaning practices could spread infection throughout the building. Record review revealed the facility admitted Resident #16 on 6/07/24 with medical diagnoses including Unspecified Sequelae of Cerebral Infarction and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 12, indicating Resident #16 was moderately cognitively impaired.		