

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER TUPELO COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1901 BRIAR RIDGE ROAD , TUPELO, Mississippi, 38804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #3193317, CI MS #3053478, and CI MS #3053893) at the facility from 9/8/2026 through 9/10/2026. CI MS #3193317 was investigated for resident rights. CI MS #3053478 was investigated for falls and quality of care. CI MS #3053893 was investigated for sufficient supplies, pressure injuries, and staffing. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F0584 was cited for CI MS#3053893 and F0550 was cited for CI MS#3193317. There were no deficiencies for CI MS# 3053478. The facility held a license for 120 beds, with a census of 102.			F0000			
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services			F0584			

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 reverse for further 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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F0584 SS = E	Continued from page 1 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident interview and staff interviews, record review and facility policy review, the facility failed to maintain a sufficient supply of clean linens to meet resident care needs for two (2) of four (4) linen carts and the main linen room observed. Findings Include: Record review of facility policy titled "Homelike Environment" revised 2/2021 revealed, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences...e. clean bed and bath linens..." During an observation and interview on 9/8/2026 at 11:31 AM, Resident #7 was lying on a regular bariatric mattress with no fitted sheet or any barrier covering the mattress. Resident #7 stated that staff told her they did not have any sheets available to put on her bed. During an interview on 9/8/2026 at 12:40 PM, Certified Nursing Assistant (CNA) #1 stated that she was unable to give a resident a bath that morning because there were no linens available. CNA #1	F0584					

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F0584 SS = E	Continued from page 2 stated that bed linens and washcloths were regularly unavailable. She stated that at times she had to improvise and wash residents with wet wipes. CNA #1 also stated that staff regularly throw away linens when they are soiled. An observation on 9/9/2026 at 9:48 AM of the clean linen room which services the entire facility revealed seven (7) flat sheets, zero (0) fitted sheets, one (1) washcloth, zero (0) towels, and six (6) blankets on the shelves for 102 residents who reside in the facility. During an interview on 9/9/2026 at 9:50 AM, Housekeeping Staff #1 confirmed the number of linens observed on the shelves. She stated that laundry operates on two (2) shifts with no overnight laundry crew. She stated that each load of laundry takes approximately one and a half hours to wash and dry. Housekeeping Staff #1 stated that the shelves are regularly empty when she arrives for work at 7:00 AM. An observation on 9/9/2026 at 9:58 AM revealed the B Wing linen cart contained zero (0) sheets, approximately six (6) towels, and three (3) pillowcases. An observation on 9/9/2026 at 10:00 AM revealed the A Wing linen cart contained zero (0) sheets, four (4) gowns, four (4) pillowcases, and six (6) washcloths. During an interview on 9/9/2026 at 10:05 AM, the Staff Development Coordinator (SDC) confirmed the number of linens observed in the clean linen room and on the A Wing and B Wing linen carts were all that they had available in the facility for resident's needs. During an interview on 9/9/2026 at 11:02 AM, the Environmental Services Supervisor confirmed there were not enough linens available. When asked if she felt the amount of linen was enough for staff to adequately do their jobs, she stated, "I know there's not!" She stated that a lot of linen must be taken out of use because of stains. She stated that they have tried using extra bleach for the stains, but it does not always work. She stated that since they changed companies, the linen is "thin and cheap." She stated there was no extra linen in storage, and when ordered linen is received, it must be placed directly on the shelves because staff need it. The Environmental Services Supervisor stated that she had reported the need for more linens to the Administrator.	F0584					

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F0584 SS = E	Continued from page 3 During an interview on 9/10/2026 at 12:08 PM, the Director of Nursing (DON) confirmed she was aware of a problem with the linen supply. She stated that stained linen contributes to the problem. The DON stated that she encourages staff to frequently return their soiled linen barrels to help maintain the linen supply. She acknowledged that staff should always have sufficient linen available to meet the needs of the residents and that a resident shouldn't have to lay on a mattress without sheets on it. During an interview on 9/10/2026 at 2:08 PM, the Administrator stated that she was aware of the problem with the linen supply. She stated that she had come into the facility in the mornings and observed beds that were not made. She stated that staff told her there was no linen available and they were waiting for it. The Administrator confirmed that the Environmental Services Supervisor had reported the need for more linen to her. She stated that she orders linen every month. The Administrator confirmed that having a sufficient supply of linen is important so staff can perform their duties without delaying resident care. Record review of "Admission Record" revealed Resident #7 was admitted to the facility on 1/9/2019 with diagnoses of Chronic Gout, Unspecified, Without Tophus, Type 2 Diabetes Mellitus without Complications, and Heart Failure, Unspecified. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/21/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #7 was cognitively intact.			F0584			
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the			F0550			

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F0550 SS = D	Continued from page 4 resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on resident interviews, staff interviews, record review and facility policy review, the facility failed to ensure a resident's right to be treated with dignity and respect for one (1) of eight (8) sampled residents (Resident #4). Findings Include: Review of facility policy titled "Resident Rights" revised 12/2026 revealed, "Employees shall treat all residents with kindness, respect, and dignity...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence..." During an interview on 9/9/2026 at 9:00 AM, Resident #4 stated that the previous night, Licensed Practical Nurse (LPN) #1 told her, "You should be ashamed of yourself; you should have pulled that wheelchair around, got out of bed and went to the bathroom." Resident #4 stated that she had an incontinent episode and was talked to badly by LPN			F0550			

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F0550 SS = D	Continued from page 5 #1 and that she reported the incident to LPN #2. During a follow-up interview on 9/9/2026 at 1:32 PM, Resident #4 stated that she got into bed at approximately 7:30 PM and had been having diarrhea. She stated that at approximately 11:00 PM, she called for assistance with incontinent care. Resident #4 stated that LPN #1 answered the call light and told her she would have to wait to be changed because rounds were completed every two (2) hours and she could not be changed more often than that. Resident #4 stated that the interaction with LPN #1 made her feel embarrassed. She further stated that between 11:00 PM and 3:30 AM, she was changed one time. During an interview on 9/9/2026 at 1:42 PM, Resident #8, who is Resident #4's roommate, confirmed that LPN #1 answered Resident #4's call light on the night of 9/8/2026 and that she heard LPN #1 tell Resident #4 that she would have to wait to be changed and to get up and go by herself. Resident #8 also confirmed that LPN #1 told Resident #4 that she was sorry and should be ashamed of herself. During an interview on 9/10/2026 at 9:51 AM, LPN #2 stated that Resident #4 reported to her that LPN #1 answered her call light the previous night and told her she could go to the bathroom on her own and that she was "laid up in the bed being sorry." LPN #2 stated that she was in the middle of medication pass when Resident #4 reported the incident, so she instructed Resident #4 to report the concern to the Administrator. LPN #2 stated that she did not report the concern to the Administrator herself. LPN #2 also stated that Resident #8 confirmed to her what LPN #1 said to Resident #4. During an interview on 9/10/2026 at 12:26 PM, the Director of Nursing (DON) stated that her expectation was for staff to treat all residents with dignity and respect, to honor their rights and to treat them like family. The DON stated that it was not appropriate for LPN #1 to tell Resident #4 that she should be ashamed of herself and acknowledged that it was a violation of the resident's rights that she was talked to that way. During an interview on 9/10/2026 at 1:47 PM, the Administrator stated that at approximately 1:00 PM on 9/9/2026, Resident #4 entered her office and reported the incident involving LPN #1. She stated that Resident #4 told her that she was having diarrhea and LPN #1 answered her call light at 11:00 PM and told her she was just being sorry, you can	F0550					

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F0550 SS = D	Continued from page 6 get up and go to the bathroom. The Administrator stated that she also interviewed Resident #8, who reported that LPN #1 entered the room and told Resident #4 that she could get up and go to the bathroom. The Administrator stated that Resident #8 also reported that LPN #1 was rude to Resident #4. The Administrator stated that she called the incident into the State Agency on 9/9/2026 at approximately 2:20 PM. The Administrator confirmed that the interaction was a resident rights and dignity concern and stated, "It is a dignity issue." Record review of "Admission Record" revealed Resident #4 was admitted to facility on 11/3/2025 and had diagnoses of Nondisplaced Fracture of Lateral Condyle of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing and Type 1 Diabetes Mellitus with Ketoacidosis Without Coma. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/24/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #4 was cognitively intact. Record review of "Admission Record" revealed Resident #8 was admitted to facility on 10/22/2025 with a diagnosis of Primary Osteoarthritis, Right Hip. Record review of the MDS with ARD of 7/26/2026 revealed, under Section C, a BIMS summary score of 15, indicating Resident #8 was cognitively intact.			F0550			