

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 10/08/2026	
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 a Complaint Investigation (CI MS #3696400) at the facility on 10/7/2026 through 10/8/2026. CI MS #3696400 was investigated for pressure injures, weight loss, and care plan meetings. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F686 was cited. The facility held a license for 120 beds, with a census of 102.		F0000				
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and review of facility policy, the facility failed to ensure a comprehensive skin assessment was completed upon admission and a pressure injury to the sacrum was identified and appropriate treatment initiated in a timely manner for one (1) of four (4) residents sampled for pressure injuries (Resident #1). Findings Include:		F0686				

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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F0686 SS = D	Continued from page 1 Record review of a facility policy titled, "Prevention of Pressure Ulcers/Injuries," dated 04/24, stated, "The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors... Assess the resident on admission for existing pressure ulcer/injury risk factors... Conduct a comprehensive skin assessment upon admission..." Record review of the Admission Record revealed Resident #1 was admitted to facility on 9/4/2026 with a diagnosis of Unspecified Severe Protein-Calorie Malnutrition. Record review of document titled, "Skin Issues," dated 09/06/26 with timestamp of 16:29, "New issue, Sacrum, Pressure ulcer/injury, Stage 3, exact date 09/04/26, present on admission, 5.81 centimeters (cm) × 2.41 cm × 0.3 cm, with an area of 9.66 cm. Rounds made by in house WC (wound care) RN (Registered Nurse) r/t (related to) admission. New orders. Cleanse Stage 3 pressure injury to sacrum with 0.9% saline then pat dry with 4x4 gauze, apply hydrogel and cover with dry dressing daily and PRN (as needed)." Record review of Resident #1's September 2026 Treatment Administration Record (TAR) revealed an order with a start date of 9/7/2026 that documented, "Clean Sacrum with NS (normal saline), pat dry with 4x4 apply calazinc and cover with dry dressing QD/PRN (every day and as needed) until healed." Discontinued on 09/07/26. Record review of Resident #1's September TAR revealed an order with a start date of 09/08/26 that stated, "Cleanse stage 3 pressure injury to sacrum with 0.9% normal saline then pat dry with 4x4 gauze, apply hydrogel and cover with dry dressing daily and PRN." During an interview on 10/8/2026 at 10:30 AM, Resident #1's Representative stated Resident #1 had a wound to the sacral area while hospitalized prior to her admission to the facility on 9/4/2026. During an interview on 10/8/2026 at 10:46 AM, the Clinical Care Coordinator stated she was not routinely responsible for completing clinical admission assessments for new admits unless she was available and specifically asked to complete one. She stated she did not recall what time Resident #1 arrived at the facility on Friday, 9/4/2026 but thought it was later in the day. The			F0686			

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F0686 SS = D	Continued from page 2 Clinical Care Coordinator stated she did not complete any assessments for Resident #1 until Monday, 9/7/2026, three days after the resident's admission. During an interview on 10/8/2026 at 12:58 PM, the Assistant Director of Nursing (ADON) stated she worked as the weekend supervisor on 9/5/2026 and 9/6/2026, following Resident #1's admission to the facility on 9/4/2026. She stated she was not aware of the time Resident #1 arrived at the facility on 9/4/2026. The ADON stated that on 9/6/2026, Resident #1's daughter and granddaughter called her to the resident's room while they were providing the resident with a bed bath and asked her to assess a skin concern to the resident's sacral area. She stated she had to separate the resident's buttocks to visualize the wound. The ADON stated she photographed the wound and identified it as a Stage III pressure injury to the sacrum, with no slough or eschar observed. She stated she reviewed Resident #1's electronic medical record to determine whether the skin concern had been identified and documented upon admission and found no documentation that an admission skin assessment had been completed and no treatment orders were in place for the wound. The ADON stated she initiated treatment to cleanse the wound with normal saline, apply Calazinc, and cover it with a dry dressing. She further stated Resident #1's daughter reported the wound had been present while the resident was hospitalized. During an interview on 10/8/2026 at 2:24 PM, the Director of Nursing (DON) confirmed Resident #1 was admitted to the facility on 9/4/2026 and stated she was unable to definitively determine the time the resident arrived at the facility. The DON stated the hall nurse was responsible for completing the clinical admission when a new resident arrived. She stated she had been unable to reach the nurses who worked on 9/4/2026 to determine whether they completed a skin assessment and why they did not initiate an order for wound care. The DON further stated the wound care nurse was responsible for completing skin assessments for all newly admitted residents and, if the wound care nurse was unavailable, the hall nurse was responsible for completing the assessment. She stated the wound care nurse was no longer employed by the facility and had not returned her calls. The DON stated that if a nurse was unable to stage a wound due to scope-of-practice limitations, the nurse should describe the area and document the findings until a Registered Nurse (RN) could assess the area. The DON confirmed that an admission skin assessment			F0686			

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F0686 SS = D	Continued from page 3 was not completed for Resident #1, and no treatment orders were initiated for the sacral wound upon admission. The DON stated it was her expectation that skin assessments be completed upon admission and that appropriate treatment be initiated when skin concerns were identified. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/11/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #1 was severely cognitively impaired.			F0686			