STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Tupelo	2273 South Eason Boulevard 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from sexual abuse for one (1) of 32 initial pool residents. Resident #14 Findings Include:Review of the facility policy titled Abuse Policy, unrevised, revealed under Policy Statement: It is the policy of the center to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of resident/patient property .Record review revealed the facility reported an allegation of abuse to the State Agency on 1/10/26 at 11:30 AM after a staff member witnessed Resident #56 touching Resident #14 inappropriately. The residents were immediately separated and Resident #56 denied the allegation, and an investigation was initiated.An observation of Resident #56 on 1/11/26 at 3:45 PM revealed he was sitting in his wheelchair outside his room doorway with a Certified Nurse Aide (CNA) sitting nearby. Resident #56 stated he had behaviors and that staff were watching him.An interview with Licensed Practical Nurse (LPN) #6 on 1/12/26 at 9:16 AM revealed Resident #56 touched Resident #14's breast over the weekend and had been placed on one-to-one supervision for observation.Record review of Resident #56's Progress Notes dated 1/10/26 revealed, Staff reported to this nurse that resident touched another resident breast. Resident stated that he did it because he loves her.Record review of Resident #56's Progress Notes dated 1/10/26 revealed the Social Worker spoke with Resident #56 regarding the allegations. The entry documented that Resident #56 did not deny the touching and told the Social Worker, That's what a man does when he is in love.An observation of Resident #14 on 1/12/26 at 10:34 AM revealed she was ambulatory and standing at the entrance of another resident's room. She was easily directed to her room and Resident #14 displayed a flat affect and responded to simple questions; however, her responses were inconsistent and suggested she did not fully understand or recall what was being asked. When questioned about the touching incident, she stated she did not remember and could not recall any part of the event.An interview with Resident #56 on 1/13/26 at 8:41 AM revealed that on 1/10/26 he was sitting at the dining table talking with Resident #14. He stated, I accidentally touched her on the breast. He reported Resident #14 told him, I love you, and stated he had been talking with her for a day or two prior to the incident and was attracted to her. He stated staff moved him back to his dining table afterward and began watching him. He acknowledged he had been attracted to other female residents before but had not touched them.An interview with Social Services (SS) on 1/13/26 at 8:53 AM revealed she spoke with Resident #56 on the date of the incident. She stated Resident #56 told her, That's what men do when they are in love. She stated he was cognitive and was educated about respecting other residents' personal space. SS reported Resident #14 was unable to recall the incident.An interview with the Director of Nursing on 1/13/26 at 2:04 PM revealed the incident occurred in the dining area and was witnessed by a CNA. She stated the residents were separated and Resident #56 was placed on one-to-one staff observation until psychiatric services could evaluate him.An interview with CNA #4 on 1/13/26 at 2:18 PM (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed she was walking toward the dining room when she noticed a dietary employee observing something occurring between Resident #56 and Resident #14. CNA #4 stated she entered the dining room and observed Resident #56 touching Resident #14's breast on the outside of her shirt while both residents sat at a dining table. CNA #4 reported she told him she was going to report the incident, and he replied, I don't care. She reported the incident to the nurse.An interview with Dietary Staff #1 on 1/14/26 at 11:19 AM revealed she saw both residents sitting together in the dining room and observed Resident #56 stroking Resident #14's face and rubbing her hair. She stated there were no staff present in the dining room at that time. She stated CNA #4 noticed the interaction and entered the room to check. Dietary Staff #1 stated she returned to her duties and did not personally witness the breast touching.Record review of Resident #56's Psychiatric Telemedicine Visit dated 1/10/26 revealed under Subjective: Earlier today, staff reported the patient inappropriately touched a female resident by rubbing her, which he acknowledges doing ‘to see her reaction,' though he expected ‘nothing' from it. He stated he likes the resident.During an interview on 1/14/26 at 3:28 PM with the Director of Nursing, she stated she was aware that all residents have the right to be free from abuse and that the facility was responsible for protecting residents from such conduct.Record review of the admission Record revealed the facility admitted Resident #14 on 12/26/25 with medical diagnoses including Unspecified Dementia, Unspecified Severity, with Mood Disturbance.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating Resident #14 was moderately cognitively impaired.Record review of the admission Record revealed the facility admitted Resident #56 on 1/27/24 with medical diagnoses including Epilepsy, Anxiety Disorder, and Unspecified Mood Disorder.Record review of the MDS with an ARD of 1/5/26 revealed under section C, a BIMS score of 15, indicating Resident #56 was cognitively intact.