MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41CH	A. BUILDING: _____ B. WING _____	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTH CENTER	2800 WEST MAIN STREET TUPELO, MS 38801

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey (CI MS #25253 and CI MS #25658) at the facility on 07/01/24. During the Survey, the SA investigated alleged abuse and determined that the facility was not in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm and cited M 500 for CI MS#25253. The facility was in compliance related to CI MS#25658 for verbal abuse. The census at the time of the complaint survey was 135 and they were licensed for 140 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically	M 500		7/26/24

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contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is

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given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the

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M 500	Continued From page 3 facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interviews, Resident	M 500	I. Employee #1 was suspended by the Green House Guide on 5/26/24 and terminated on 5/29/24 by the Administrator. A body audit and functional	

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M 500	Continued From page 4 Representative (RR) interview, record review and facility policy review, the facility failed to ensure that one (1) of five (5) sampled residents were protected from physical abuse. Resident #1. Findings included: Record review of the "Abuse, Neglect, and Exploitation" facility policy dated 03/15/2024, revealed under Policy: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." On 07/01/24 at 10:00 AM, a brief interview with the Administrator revealed that she reported an incident involving a Certified Nursing Assistant (CNA) who aggressively transferred a resident from the bed to her wheelchair and it was recorded on the ring camera that had been placed in the resident's room by her family. On 07/01/24 at 10:15 AM, an interview with the Administrator (ADM) revealed that on the morning of 05/26/24, Resident #1's Resident Representative (RR) sent a "snippet" of a video that was recorded on the ring camera to the CNA Supervisor. The ADM revealed that Resident #1's RR felt like the employee was "rough" with her. ADM said that she viewed the video which showed that CNA #1 was transferring Resident #1 from the bed to the wheelchair, and Resident #1 leaned back resisting care and let go of the rail. The ADM revealed that Resident #1 then stated "Ain't nobody worth a damn" and CNA #1 roughly grabbed Resident #1 under her arm pits and did a quick transfer into the wheelchair. The	M 500	range of motion assessment was conducted on Resident #1 by the Registered Nurse Clinical Coordinator on 5/27/24. II. All residents in the Green House where Employee #1 worked at the time of the incident were identified as having the potential to be affected. All interviewable residents in the Green House where Employee #1 worked at the time of the incident, were interviewed by the Administrator to ensure no other residents had been affected by the deficient practice. No other concerns were identified. III. A body audit was conducted by the Director of Nursing and Assistant Director of Nursing on 5/28/24 on all residents in the Green House where Employee # worked at the time of the incident with no other concerns identified. An inservice was initiated regarding abuse and neglect on 5/27/24 by the Green House Guide and will be completed by 7/22/24 for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants. On 5/28/24 the Registered Nurse Educator initiated an inservice on resident transfers for Certified Nursing Assistants and will be completed by 7/22/24. IV. The Director of Nursing, 7PM-7AM Registered Nurse Clinical Coordinator, or Green House Guides are performing transfer audits at least one a day for 30 days, starting on 7/1/24 through 7/30/24, then weekly for 4 weeks. An emergency Quality Assurance and Performance Improvement (QAPI) committee meeting was conducted on 5/28/24 and another QAPI meeting is scheduled for 7/25/24	

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M 500	Continued From page 5 ADM stated, "It made me cringe." ADM revealed that they suspended CNA #1 pending investigation and because of the aggressive handling, she terminated her. ADM revealed that they did a full body audit on Resident #1 and found some bruising under her left armpit and some scattered bruising on both arms that were now healed. She revealed that Resident #1 had Dementia, required more assistance, and needed the staff to be patient with her, allow her more time and not get in a hurry. ADM confirmed that this transfer was too aggressive and stated, "I'm just sick over it." ADM revealed that she called CNA #1 in to watch the video and write a statement and CNA #1 reported that Resident #1 had been more resistant to getting up and said she should have left her in bed. ADM revealed that CNA #1 also told her that when Resident #1 let go of the transfer bar, she made the instant decision to transfer her quickly to the wheelchair. The ADM stated that CNA #1 was remorseful and revealed that she had no idea until after watching the video as to how quickly she transferred Resident #1. ADM revealed that CNA #1 did not intentionally harm Resident #1, but a bruise was found under her left armpit and scattered bruising on bilateral arms. ADM revealed that she terminated CNA #1 on 05/29/24 because of the incident. On 07/01/24 at 11:55 AM, an interview with Director of Nursing (DON), revealed that she watched the video a couple times and was shocked and saddened that this incident happened with one of their residents. She revealed that it broke her heart to think that they had someone working with these residents who had no compassion. DON revealed that the staff knew that the family was not able to be there often to see Resident #1 and they had a video	M 500	and 8/29/24 to review and revise the plan of correction if additional concerns are identified through the transfer audits.	

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camera in her room so they could see her. She stated that Resident #1's family trusted them to take care of her and they let them down. She stated, "I hate this happened."

On 07/01/24 at 12:15 PM, an interview with CNA Supervisor, revealed that on Saturday morning, May 26, 2024, Resident #1's RR sent her a video that showed that CNA #1 entered the room of Resident #1, dressed her, and was aggressive with her during transfer from the bed to her wheelchair. CNA Supervisor revealed that she saw and heard on video that Resident #1 said that no one was "worth a damn" around there and then CNA #1 moved quickly and did a swift transfer. CNA Supervisor revealed that CNA #1 should have managed her time better to avoid being in a hurry, should have allowed Resident #1 more time to transfer or she should have waited on someone to help with the transfer.

On 07/01/24 at 12:50 PM, a phone interview with Resident #1's RR revealed that she had a ring camera placed in her sister's room and she watched how the staff treated her. She revealed that on the camera footage on 05/26/24, she observed CNA #1 enter the room to get her up and dressed at 5:30 AM, and stated, "She practically grabbed her up and throwed her into the wheelchair." RR revealed CNA #1 did not have any patience with her and seemed to be in a hurry and stated, "I hope she hasn't treated anyone else like this." Resident #1's RR revealed that she reported this to CNA Supervisor and that CNA #1 had been fired.

The State Agency (SA) had attempted to contact CNA #1 several times throughout the investigation and on 07/03/24 at 8:27 AM, CNA #1 returned the phone call. The interview with

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CNA #1, revealed that she worked at the facility on an "As Needed" basis and had another full-time job. She revealed that she hadn't worked in two weeks prior to the incident with Resident #1. CNA #1 revealed that on the morning of 05/26/24, she entered Resident #1's room, cleaned her up and dressed her, and when she was ready to transfer her, Resident #1 would not budge. She revealed that prior to this day, Resident #1 would follow commands and help during the transfers. CNA #1 revealed that she was already pressed for time and decided to swiftly transfer her to her wheelchair. CNA #1 revealed the Administrator called her back in to watch the video and she confirmed that it looked like a rough transfer but that was never her intention. She revealed that she normally asked for help with residents, but the nurse wasn't there, and she stated, "So I hurried and picked her up, put her in the chair before either of us got hurt." CNA #1 revealed this was a mistake on her end and that she should have left Resident #1 in the bed until she could get help with the transfer because safety should always come first.

Record review of CNA #1's Timesheet revealed that she clocked in on 05/25/24 at 10:57 PM and clocked out on 05/26/24 at 7:16 AM and this was the last date that she worked.

Record review of CNA #1's written "Statement" revealed that she had bacon in the oven and had gone into Resident #1's room to get her up and noticed that she was a little more irritable than normal. CNA #1 revealed that when she went to put her shirt on, she leaned back with hesitation. CNA #1 revealed that she pulled resident towards her preparing to pivot, realized Resident #1 had let go of the rail and then took the opportunity to move very quickly to prevent from hurting the

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resident and herself during the transfer. CNA #1 included in her statement an apology and stated that this was not the appropriate way to transfer a resident.

Record review of the "Offense/Incident Report" completed by the Police Department on 05/28/24 revealed that an officer was dispatched to the facility in regards to a patient being mistreated by an employee. ADM reported to the officer that the ring camera from Resident #1's room was able to record the whole incident. "In the video you see CNA #1 aggressively grabbing under Resident #1's arms to the extent that it left noticeable bruising under Resident #1's arms." Officer was able to watch the video of CNA #1 aggressively picking up Resident #1 and in a "throwing motion" placed her from the bed to the wheelchair.

Record review of Resident #1's "Progress Note" dated 05/26/24, revealed that Resident #1's RR observed on camera in her sister's room in the early morning that she was transferred in an aggressive manner from CNA #1 and she did not want this CNA to take care of her sister anymore.

Record review of Resident #1's "Progress Note" dated 05/27/24 revealed that she had noted a bruise to her left armpit and scattered bruising to her bilateral arms.

Record review of Resident #1's "Admission Record" revealed an admission date of 11/08/2021 and she had diagnoses that included Alzheimer's Disease and Vascular Dementia.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/10/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) score of

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M 500	Continued From page 9 03 which indicated that she had severe cognitive deficits. Record review of Resident #1's "Weekly Nursing Note and Skin Audit" form dated 05/27/24 revealed that a bruise was noted to left armpit and scattered bruising to bilateral arms.	M 500		