STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS# 25253 and CI MS #25658) at the facility on 07/01/24. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid services. The SA investigated alleged physical abuse and cited F600 for CI MS #25253. The SA did not find non-compliance related to CI MS#25658 for verbal abuse. The census at the time of the complaint investigation was 135 and they held a license for 140 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, Resident Representative (RR) interview, record review and facility policy review, the facility failed to ensure	F 600	I. Employee #1 was suspended by the Green House Guide on 5/26/24 and terminated on 5/29/24 by the	7/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/16/2024

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F 600	Continued From page 1 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 ADM stated, "It made me cringe." ADM revealed	F 600	Administrator. A body audit and functional 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 on 5/27/24 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 #1 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 Houses Guides are performing transfer audits at least once a day for 30 days, starting on 7/1/24, then weekly for 4 weeks. An emergency Quality Assurance and Performance Improvement (QAPI) committee meeting was conducted on	

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F 600	Continued From page 2 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	F 600	5/28/24 and another QAPI committee meeting is scheduled for 7/25/24 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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F 600	Continued From page 3	F 600		

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

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F 600	Continued From page 4	F 600		

#1 returned the phone call. The interview with 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

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F 600	Continued From page 5	F 600		

let go of the rail and then took the opportunity to move very quickly to prevent from hurting the 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

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F 600	Continued From page 6 Set (MDS) with Assessment Reference Date (ARD) of 05/10/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 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.	F 600		