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 05/05/2025

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS #28759) at the facility on 05/05/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F689. The census at the time of the survey was 130 and they held a license for 140 beds.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff, and resident, caregiver, and responsible party interviews, record review, and facility policy review the facility failed to accurately complete an elopement assessment and identify risks to prevent an unsupervised resident from exiting the facility door for one (1) of three (3) residents reviewed for elopement and wandering. Resident #1. Findings Include: Review of the facility policy, "Accidents and Interventions" dated 05/05/19 revealed, "The resident environment will remain as free of accident hazards as is possible. Each resident	F 689	1. At 7:20pm Resident #1 was assessed for injuries with none found by the Registered Nurse (RN) Clinical Coordinator on 4/26/25. The RN/ Director of Clinical Support, updated Resident #1 wandering and elopement assessment and the RN, Director of Nursing updated Resident #1 care plan on 4/26/25. A wander guard bracelet was added on Resident #1 right arm by the RN Clinical Coordinator and a one-on-on sitter was assigned to Resident #1 by the administrator on 4/26/25. 2. The Registered Nurse (RN) Clinical Coordinator re-assessed all residents on	6/5/25

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

Electronically Signed | 05/16/2025

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F 689	Continued From page 1 will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s)....." An interview on 05/05/25 at 8:45 AM with Administrator (ADM), revealed that on 04/26/25, they had a resident to propel himself in his wheelchair outside the facility through an automated sliding door. She revealed that Resident #1 had been at the facility less than a week, he had limited mobility, and there had been no indications that he was an elopement risk. ADM revealed that on 04/26/25 at 7:20 PM, two resident assistants brought Resident #1 from the Assisted Living side, over to the 700 hall of the rehabilitation unit where he resided. She revealed that the resident assistants informed staff that Resident #1 was outside the automatic doors in his wheelchair. ADM revealed that they thought he belonged in the assisted living department and assisted him back into the building. ADM revealed that she arrived at the facility, reviewed the video surveillance, and determined that Resident #1 exited the front of the building through the automatic sliding glass doors and he was assisted back into the assisted living area of the building. An interview on 05/05/25 at 9:20 AM with ADM, revealed that Resident #1 had an elopement risk evaluation completed on admission and had a risk of zero for wandering and elopement documented. She revealed that when a resident's cognition was not good, they had to go by what the family said and the family had not told them that he had elopement risks. An observation and interview with the resident sitter on 05/05/25 at 9:40 AM, revealed Resident	F 689	the Cedars Health Center Rehabilitation Unit for the potential of wandering and elopement on 4/26/25, to identify any other residents having the potential to be effected. No other residents were identified to be at risk on 4/26/25. All residents admitted prior to 5/5/25 families were called to ensure a complete history of wandering and elopement was obtained on 5/16/25 by the RN Clinical Coordinator to adequately identify anyone at risk of wandering and elopement. Admissions since 5/5/25 have a complete history of wandering and elopement to identify anyone at risk of wandering and elopement. 3. An in-service was initiated on 4/26/25 by the administrator for the prevention of wandering and elopement and concluded on 4/27/25 for all staff working at Cedars Health Center Rehabilitation unit. An emergency quality assurance and performance committee meeting was conducted by the administrator in person and by cellular phone on 4/26/25 to review the policy for any necessary revisions and to discuss approaches for the prevention of wandering and elopement. On 4/28/25 a review of current Brief Interview for Mental Status (BIMS) scores was conducted by the administrator of the residents staying in the Cedars Health Center Rehabilitation Unit and a decisions was made by the interdisciplinary care plan team that included the Director of Nursing, RN Clinical Coordinator, and Social Worker that a wander guard bracelet would be placed on any resident with a BIMS score of 12 or below and was	

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F 689	Continued From page 2 #1 sitting in his room in his manual wheelchair with his private caregiver sitting beside him. Resident #1 had a wander guard bracelet intact to his right arm. The caregiver revealed that was now sitting with Resident #1 during the day. She revealed that this behavior wasn't new for him, that at home, he would go outside during the night. A phone interview on 05/05/25 at 10:25 AM with Resident #1's Responsible Party (RP), revealed that he had dementia, he was confused a lot, and he lived with her prior to coming to the facility. She revealed that Resident #1 fell on 04/18/25 at her house, broke his hip, had surgery and from the hospital, he admitted to the facility for therapy. She revealed that he had been there for four or five days when he got out of the facility. Resident #1's RP confirmed that he had wandered at home, he got out of the house at night, and they had to put alarms on all of the outside doors and they put cameras up. Resident #1's RP revealed that she signed his admission paperwork when he was admitted to the facility and she said the staff never asked her if he wandered or if he had ever gotten out of the house. Resident #1's RP confirmed that she didn't think he would go anywhere because he had a broken hip and was in a wheelchair and she never said anything to the facility. An interview on 05/05/25 at 11:10 AM with Registered Nurse (RN) #1, revealed that she completed all the admission assessments and evaluations during the admission process including the "Elopement Evaluation." She revealed that if the resident was not able to give a good history or answer questions appropriately, she asked the family. RN #1 revealed that	F 689	mobile for the prevention of leaving the building unassisted. An inservice has been initiated on 5/16/25 for nursing staff on adequately obtaining a former history of wandering and elopement by the Director of Nursing and will be completed by 5/23/25. The facility will ensure a complete history of wandering and elopement is obtained on the day of admission and a wander guard bracelet will be placed on the resident on the day of admission if the BIMS score is 12 or below to ensure the problem does not recur. Residents with a wander guard bracelet will be added to the medication administration record (MAR) to check placement and functionality daily. 4. The Director of Nursing and/or the Assistant Director of Nursing will review all newly admitted resident's wandering and elopement assessments for accuracy weekly for four weeks then monthly for one quarter starting on 5/16/25. The Director of Nursing, Assistant Director of Nursing, and/or RN Clinical Coordinator will audit the MAR daily for one month to ensure the wander guard bracelet is being monitored daily by the charge nurse starting on 5/20/25. A quality assurance and performance and improvement (QAPI) committee meeting is scheduled for 5/22/25, 5/29/25, 6/5/25, and monthly for one quarter to review and revise the plan of correction if additional concerns are identified through the audits.	

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F 689	Continued From page 3	F 689		

Resident #1 was confused, and she spoke with the RP about his history of wandering. RN #1 revealed that the RP didn't verbalize any issues or concerns with Resident #1 at that time, and that she usually asked in a more casual way about their behaviors at home and confirmed that she did not directly ask the question that was on the "Elopement" Assessment Form, "Does the Resident have a history of elopement or an attempted elopement while at home?" She revealed that she tried to make the admission process more personable with the family and she asked general questions. RN #1 revealed that during Resident #1's Elopement Risk Assessment, there was nothing said that would indicate that the resident had a history of wandering or elopement. RN #1 revealed that she would make sure and clarify from now on, so the question would be answered properly to ensure the safety of the residents.

A phone interview on 05/05/25 at 4:12 PM, a phone with Registered Nurse Clinical Coordinator (RNCC), revealed that she received a phone call from the hall nurse on 04/26/25 that Resident #1 had gotten out of the facility unsupervised. She revealed that she came to the facility and checked him out. She revealed that he was very confused but was not hurt. She revealed that she called Resident #1's daughter, and she told her that he had been obsessed with locked doors at home prior to coming there and RNCC revealed that she did not verbalize that he had these wandering behaviors before.

Record review of Resident #1's Admission "Elopement Evaluation" dated 04/21/25 revealed the question, "Does the Resident have a history of elopement or an attempted elopement while at

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F 689	Continued From page 4 home" and the answer "No" was marked. Record review of Resident #1's "Admission Record" revealed an admission date of 04/21/25 and that he had diagnoses that included Displaced Intertrochanteric Fracture of Right Femur and Dementia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/28/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 06 which indicated that he had severe cognitive deficits.	F 689		