STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTH CENTER	**2800 WEST MAIN STREET , TUPELO, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) for CI MS #2643975 at the facility from 10/20/25 through 10/22/25. The SA determined the facility was not in compliance with the Requirements of Participation in Medicare and Medicaid related to CI MS #2643975 for resident neglect and cited F600. On 10/14/25 at approximately 10:16 AM, after returning to the facility from an appointment the facility abandoned Resident #1 on the facility's transport van. Resident #1 was left alone and unattended on the facility transport van for approximately two hours. At 12:15 PM, the facility staff located Resident #1 still strapped in the facility transport van. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The facility's neglect to provide ordered care and services placed Resident #1 and other residents who use the facility transport van for transfers in a situation that could likely lead to serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 10/22/25 and provided the Administrator with the IJ template. The IJ and SQC existed at: 42 CFR 483.12 (a)(1) Freedom from Abuse, Neglect, and Exploitation - F600, Scope and Severity "J". Based on the facility's implementation of corrective actions taken on 10/14/25, this deficient practice was determined to be Past Non-Compliance (PNC) and the IJ and SQC removed on 10/15/25, prior to survey entrance on 10/20/25. The facility had a census of 124 at the time of the survey and held a license for 140 beds.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600	"Past Noncompliance - no plan of correction required"	

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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F0600 SS = SQC-J	Continued from page 1 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 facility policy review, record review and interviews, the facility failed to ensure a resident's right to be free from neglect for one (1) of four (4) sampled residents, Resident #1. On 10/14/25 at approximately 10:16 AM, after returning to the facility from an appointment the facility abandoned Resident #1 on the facility's transport van. Resident #1 was left alone and unattended on the facility transport van for approximately two hours. At 12:15 PM, the facility staff located Resident #1 still strapped in the facility transport van. This resulted in Resident #1 missing her hydration, care and expressing a fear that she was anxious, and thought she would die. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) at Past Non-Compliance (PNC). The SA determined the IJ began on 10/14/25 when the facility abandoned Resident #1 on the facility transport van and was removed on 10/15/25 when the facility put measures in place to protect all residents from further abuse and neglect. The facility's neglect to provide ordered care and services placed Resident #1 and other residents who use the facility transport van for transfers in a situation that could likely lead to serious injury, harm, impairment or death. The IJ and SQC existed at: 42 CFR 483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation - F600, Scope and Severity "J" PNC. The SA notified the facility's Administrator of the IJ and SQC at PNC on 10/22/25 and provided the	F0600		

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F0600 SS = SQC-J	Continued from page 2 Administrator with the IJ template. Based on the facility's implementation of corrective actions on 10/14/25, the SA determined the IJ and SQC to be PNC and the IJ was removed on 10/15/25, prior to the SA entrance into the facility on 10/20/25. Findings include: Record review of facility policy titled, “Abuse, Neglect, and Exploitation” dated 3/15/24, revealed, “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. … ‘Neglect’ means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress”. During an interview with Resident #1’s representative on 10/21/25 at 12:40 PM, it was revealed that the resident was transported to and from an appointment by the facility’s Transportation Aide (TA). Resident #1 left the facility around 7:45 AM and around 10:00 AM she was secured in the bus to be taken back to the facility. The resident’s representative went to the facility to have lunch with the resident, and the facility staff could not locate her. The TA was notified, and she reported that she had brought the resident back earlier that morning then she realized that she had been left on the bus. When the resident returned to the room, she was “soaking wet”, hot, thirsty, face was puffy and was extremely weak and tired. She revealed that the resident told her she was scared and thought she was going to have to spend the night on the bus and was even concerned that she would not survive the incident. The representative acknowledged that this incident caused the resident emotional distress, and she was now afraid to be transported in the facility’s bus. An interview with Resident #1 on 10/20/25 at 1:30 PM, revealed she was left alone on the bus after a doctor’s appointment. When they arrived at the facility, the driver got out of the bus and went into the building. The resident was hoping someone would come back to get her, but it was a long time before they returned. Resident #1 stated, “I had no water and no phone, and I just sat there in that heat ... The sun was shining and beating down, and I was hot and so thirsty for water and air”. She stated she kept praying, “Lord, it’s just	F0600		

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F0600 SS = SQC-J	Continued from page 3 my time to die. I don't see no way out and nobody knows I'm here. I can't walk and I don't have a phone to call for help". She stated that being in the bus for so long "made me sick and upset and I had to settle myself down" and "nothing like that had ever happened in my life". During the interview, the resident was in her wheelchair in her room and was pleasant and could articulate with her account of the event that occurred. During a phone interview on 10/21/25 at 4:07 PM, the Transportation Aide (TA) revealed she took Resident #1 to the hospital for a test and returned to pick her up to take her back to the facility around 10:00 AM. She returned to the facility, parked the bus, got out, and went inside the building. Around lunch time, Certified Nursing Assistant (CNA) #1 called her to ask about Resident #1 and she informed her that she had brought her back earlier that morning. She then realized that she did not remember returning the resident to her room, so she went to the bus and found the resident positioned where she had been secured. The resident was alert and said she was hot, but okay and was glad she came to assist her off the bus. She and CNA #1 got the resident out of the bus and back to her room. She acknowledged she had a lot on her mind, and she failed to ensure the resident was cared for appropriately and taken off the bus and returned safely to her room inside the facility. She stated she had been in-serviced on abuse and neglect, but she was uncertain when that was. During a phone interview with Certified Nursing Assistant (CNA) #2 on 10/20/25 at 4:22 PM, it was revealed that when the resident was returned to her room, she was "tired and weak" and "scared and shaken up". She said her mouth was dry and she drank some water. Her pants were soaking wet from where she had urinated on herself. A phone interview with CNA #3 on 10/20/25 at 4:27 PM, revealed when the resident returned to her room, she looked tired and the areas around her eyes were red and puffy, and her blood pressure was slightly elevated. She stated the resident said she was scared when she was left on the bus and was happy to see everybody's faces. During an interview on 10/21/25 at 11:30 AM, CNA #4 revealed at lunch time around noon on 10/14/25, Resident #1's representative asked her where the resident was. They looked in therapy, resident's room, and other rooms and could not locate her. They contacted the TA and was told that the resident was brought back earlier. Shortly after that, the TA	F0600		

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F0600 SS = SQC-J	Continued from page 4 brought the bus to the door. She was panicked and said, “Oh my God, she’s been on the bus for hours!” The resident kept telling the staff, “Baby, I’m so glad to see y’all”. The representative was in the room and very upset and the resident told her representative that it was upsetting and frightening, but “I’m alive!” During an interview on 10/21/25 at 2:45 PM, the Director of Nursing (DON) revealed it was her expectation that the bus be checked each time it was parked to ensure that no residents were left on the bus. She acknowledged that a vulnerable resident being left in a closed bus in the heat could lead to harmful health consequences and even death. She confirmed the facility neglected a resident’s needs when they failed to provide appropriate care when the resident was left alone on a closed bus for approximately two (2) hours with no care or supervision. A phone interview with CNA #1 on 10/22/25 at 10:56 AM, revealed on 10/14/25 around 12:00 PM, Resident #1’s representative was looking for the resident, so the staff started searching for her. The TA was contacted, and she stated she had returned the resident earlier that morning. The staff continued to search for the resident. The TA then came to the door with the resident and said she had been left on the bus. The resident was taken to her room to get cleaned up and assessed. She revealed the resident was alert, but her hands were swollen, her eyes were red, her face was puffy, and she looked very tired. She stated the resident told her she was okay now that she was found and told the staff, “I’m so glad to see your faces!”. During an interview on 10/22/25 at 8:55 AM, the Administrator in Training (AIT) acknowledged that Resident #1 was in a closed bus on a sunny day with an outside temperature approximately 82 degrees for a two (2) hour time frame. He stated that this incident had the potential for severe health complications for this vulnerable resident. He acknowledged his expectation was for each resident to receive their needed care. He confirmed the facility neglected to meet Resident #1’s care and safety needs when they failed to ensure she was removed from the bus and placed into the safety of her room in the facility. Phone interviews with the Administrator on 10/21/25 at 2:06 PM and 10/22/25 at 10:02 AM revealed it was her expectation that each resident receive appropriate care. She confirmed the facility neglected to provide the necessary care for an approximate two (2) hour time frame while Resident #1 was left in a facility bus, alone, unattended, with no supervision. It was a sunny	F0600		

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F0600 SS = SQC-J	Continued from page 5 day with the temperature approximately 79-82 degrees. She acknowledged that this incident could have had a devastating outcome for this vulnerable resident. She also acknowledged that annual training for abuse and neglect was necessary for all staff members, and it was her responsibility to ensure the Transportation Aide was current with her training. She confirmed that the facility failed to in-service TA on abuse and neglect since her last in-service in May 2024. On 10/22/25 at 2:20 PM, a phone interview with the Medical Doctor revealed he was notified of the incident involving Resident #1 being left on the bus for approximately two hours. He came to the facility to evaluate the resident and gave orders for frequent vital sign monitoring and for lab work. Oral hydration was encouraged. He stated he could not understand how this could happen to a resident and said she was fortunate that she was found as soon as she was, otherwise, the outcome could have been devastating. He revealed with the resident's comorbidities and health status, the potential for serious complications was present. He also revealed that he wanted the resident to be evaluated by a cardiologist for her heart condition, but due to this incident, she was frightened to go on the bus. He stated that both the resident and the resident's representative requested that the appointment be postponed until the resident returns home. Review of timeanddate.com weather review revealed on 10/14/25 at 12:00 PM the outside temperature range was from 79 – 82 degrees and sunny in the town where facility was located. Record review of Transportation Aide's most recent acknowledgment of abuse and neglect training was signed on 5/29/24. Record review of the "Corrective Action Form" for Transportation Aide dated 10/14/25 revealed "Disciplinary Suspension" due to "Violation of company rules of conduct" and "Improper conduct". Record review of "HR (Human Resources) Action Form" dated 10/17/25 revealed the Transportation Aide's reason to take off payroll was "Voluntary Resignation". Record review of Transportation Aide's statement revealed, "On Oct. 14, 2025, I picked up (proper name of Resident #1 removed) from (proper name of hospital removed). I loaded her in the back of the bus, strapped her down and started back to (proper name of facility removed) to unload her. As I was almost to (proper name	F0600		

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F0600 SS = SQC-J	Continued from page 6 of facility removed) I got a phone call from (proper name removed) (activities lady) inquiring if she could use one of the busses to take (proper name of a resident) to the bank that day. I was telling her we needed to put new bus in the shop and I would have to check to see if other bus was going to be available. She also was wanting to know if she was scheduled to use the new bus Friday. I already had 2 emails from people wanting to use the bus. My thought was on trying to figure this bus thing out. I parked the bus went into my office and was checking my appointment schedule for the busses. I didn't realize I hadn't unloaded (proper name of Resident #1 removed) until (proper name of CNA #1 removed) called me. I went to the bus where (proper name of Resident #1 removed) was. Asked if she was OK and if she was hot. She replied, 'I thought y'all had forgot me, but I am OK'. I then took her to (proper name of facility's building removed) and unloaded her". Record review of "Progress Note" for Resident #1 on 10/14/25 revealed, "During post incident assessment of elder, elders skin visualized with no redness, rashes, bruising or open areas noted. Skin warm and dry to touch and intact throughout. Skin turgor good, color appropriate to ethnicity. Resident denies any pain or discomfort. Elder has edema to BLE (bilateral lower extremities) and swelling to right hand, which is baseline for elder". Record review of Medical Doctor's progress note with encounter date of 10/14/25 revealed, "Notified around 12:30 PM today that patient had an appointment today. She was transported back to (proper name of facility removed) but was left in the van for 1 to 2 hours. Patient seen and examined … Family members present. Patient notes generalized weakness but denied other symptoms. Family member states she looked drenched when they saw her earlier. She did not eat breakfast or lunch. She has not had much to drink. On exam, she is sitting in her recliner. Lungs CTAB (clear to auscultation bilaterally). No increased work of breathing. On room air. Will encourage oral hydration. Patient had AKI (Acute Kidney Injury) on CKD (chronic kidney disease) with recent hospitalization; creatinine has been down trending. With this event, will recheck BMP (Basic Metabolic Panel) today. Will check vital signs every 30 minutes and space if normal. If tomorrow, vital signs are normal, will resume routine vital checks." Record review of "Admission Record" revealed the facility admitted Resident #1 on 9/10/25 with diagnoses of Paroxysmal Atrial Fibrillation and Chronic Kidney	F0600		

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F0600 SS = SQC-J	Continued from page 7 Disease. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/17/25 revealed a Brief Interview for Mental Status (BIMS) of 10 which indicated a moderate cognitive impairment. The SA validated on 10/22/25 that the facility had put measures in place to remove the immediacy of the event and had immediately acted to protect Resident #1 and all other residents in the facility. The facility had an emergency Quality Assurance (QA) meeting, began in-services with all staff, completed a health assessment and monitoring for Resident #1, notified reporting officials of the incident and continued to monitor through their QA program. The Director of Nursing and Assistant Director of Nursing will utilize End-of-Route Witness Audit Form to monitor both the vehicle walk-throughs and the completion of the End-of-Route Two-Person Checklist. Monitoring will occur daily for two weeks, then three times per week for the following two weeks, weekly for the next four weeks, and monthly thereafter. All measures were completed or began on 10/14/25 and the SA confirmed the plan of corrections that were put in place and found that the facility was PNC as of 10/15/25, prior to the SA entrance into the facility on 10/20/25.	F0600		