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 05/04/2021

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 survey for MS#17441, MS#17620, MS#17685, MS#17775, and MS#17784 at the facility from 04-29-2021 to 05-04-2021. During the survey, the SA determined that the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA substantiated Complaint MS#17741 for resident abuse concerning mental abuse, involuntary seclusion, exploitation, and misappropriation of residents property, and MS#17775 for verbal abuse and cited F600 and F609 at a D level. MS#17620 for Quality of Care and Treatment regarding assessments, medication administration, neglect and verbal abuse, MS#17685 for Resident Rights and Improper incontinent care, and MS# 17784 for Sexual Abuse, were all unsubstantiated with no deficiencies cited. Census at the time of the survey was 126.	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;	F 600		6/9/21

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

Electronically Signed | 06/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review and facility policy review, the facility failed to prevent verbal abuse and failed to prevent mental abuse via threats of punishment or deprivation, exploitation of an elder via intimidation and threats, misappropriation of an elder's property without her consent, and involuntary confinement or seclusion via the removal of a resident's property for two (2) of ten (10) residents reviewed for abuse. Residents # 1 and Resident #9. Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation", dated 01-25-2017, revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, and involuntary seclusion... Policy Explanation and Compliance Guidelines: 3. "Willful" means the individual deliberately, not that the individual must have intended to, inflict injury or harm. 7. "Mental Abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation... 9. "Involuntary Seclusion" refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will... 10. "Exploitation" means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. 11. "Misappropriation of Resident Property" means the deliberate misplacement, exploitation, or wrongful temporary or permanent, use of the a resident's belongings or money	F 600	1. An investigation was initiated and Licensed Practical Nurse (LPN) #1 was suspended on 04/23/21 and terminated on 05/04/21 by the Administrator. The Social Worker and Administrator interviewed and counseled with Resident #1 on 04/23/21. An investigation was initiated and Housekeeper #1 was suspended on 01/05/21 and terminated on 01/06/21 by the Executive Director. Resident #9 was interviewed and counseled with by the Executive Director, who is a Licensed Professional Counselor (LPC) on 01/05/21. 2. Every resident living in the Green House Home where the employees worked had the potential to be affected. The Administrator interviewed residents from 04/23/21 through 04/26/21 living in the Green House Home to identify any other resident having the potential to be affected with no other concerns identified with regards to Resident #1. Also, nurse's notes from LPN #1 were read to ensure no other residents were identified to have concerns with abusive behavior by the writer written in the notes by the Regional Nurse Consultant on 06/09/21. The Executive Director interviewed residents on 01/05/21 living in the Green House Home to identify any other residents having the potential to be affected with no other concerns identified in regards to Resident #9. 3. Educational in-servicing was initiated on 04/23/21 regarding Resident's Right Abuse and Neglect by the Administrator	

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	255309	A. BUILDING _____ B. WING _____	C 05/04/2021

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F 600	Continued From page 2 without the resident's consent." Resident #1 Review of Resident #1's Face Sheet revealed she was admitted to the facility on 08-11-2017 with diagnoses of Dementia with Behavioral Disturbance, Hypertension, Depression, Hyperlipidemia, Gastroespophageal Reflux Disease, Neuropathy, heart Failure, Chronic Obstructive Pulmonary Disease, Insomnia, Anxiety, Obesity, Diabetes Mellitus, Hemiplegia, Chronic Kidney Disease, Osteoarthritis, Peripheral Vascular Disease, Disorder of the Adrenal Gland, and Psychosis. Review of Resident #'1's Minimum Data Sate (MDS) dated 04-13-2021, revealed, she had a Brief Interview of Mental Status (BIMS) of 15, making her interviewable, and cognitively able to answer questions, and she required extensive assistance for her activities of daily living (ADL's) and was always incontinent of bowel and bladder. On 04-30-2021 at 10:40 AM, during an interview with Resident #1 she stated, "The nurse came in and sat on the bed and she yelled at me to turn the TV down. It was loud, I will say that. When she sat on the bed, my bed made a popping noise. I asked her if she broke my bed and she said, "why would you ask me that, I am not that fat?" She screamed at me again to turn down the TV, and I tried but she was sitting in the way. I told her if she would move her fat ass, I could turn it down. She put her finger in my face and told me I was "rude and that it wouldn't be tolerated". She reached over to give me my insulin shots, but she did it too high on my ribs and I hollered. She apologized and went to give me my second shot	F 600	for employees. The Executive Director initiated an education in-service with Housekeeping staff on 01/5/21 regarding Resident's Right Abuse and Neglect and reporting allegations timely. An acknowledgment form was created for employees to sign on 06/02/21 by the Administrator reiterating Cedars Health Center's zero tolerance for any form of abuse and to report any allegations immediately. The Executive Director continues to visit with Resident #1 and Resident #9 to ensure no additional mental distress is unaddressed. Resident #1 and Resident #9 has had no additional concerns. Resident #1 and Resident #9 care plan was updated by the Minimum Data Set (MDS) nurse to continue to monitor for signs of distress on 06/09/21. 4. The Social Worker will conduct monthly Resident Counsel meetings in each of the Green House Homes and Cedars Health Center for six months starting in June 2021, and document the results to monitor and ensure no resident abuse has occurred. The Director of Nursing and/or Registered Nurse (RN), clinical coordinators, will review nurse's notes three times a week for four weeks to ensure documentation does not identify concerns with abuse starting 06/09/21. The Administrator and/or Green House Guide will interview five employees a week for four weeks to ensure no allegations of abuse exist and if so, are thoroughly investigated and reported to the appropriate agencies in accordance with regulations and facility policy starting 06/09/21./ All findings will be reported to	

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F 600	Continued From page 3 in the same area and it hurt too so I hit her on the arm with the remote. She pried my fingers off the remote. It really hurt my hand. She took the remote from me and put it on the TV stand, and then turned around and unplugged the TV from the wall and told me "when you can treat others with respect you can have your remote back and can watch TV". She left out of the room. I would guess it was an hour or better before anyone came back into the room to give me my remote back. I had kinda dozed off, I don't remember if it was an aide or her to be honest. But this is not the first time she has done this. It has happened before with her, not for a while, like several months, but it has happened before. I am worried that she is trying to give me an air bubble sometimes to shut me up. I know I am paranoid sometimes and get excited, but I was told she was working tonight and I'm nervous because I am the reason she has been suspended and missed money." Review of Resident #1's Departmental Notes, dated 04-19-2021 at 10:31 PM, revealed, "Elder became upset et (and) very agitated w/ (with) me upon administering medication et insulin to her. Upon entering her room, elder had her TV (television) extremely loud. I asked elder to cut it down. Elder ignored me... as I prepared to administer the insulin, I sat on the edge of her bed to gain betterview. Elder only wants her insulin injections in her left lower abdomen, despite needing to rotate the sites out. Once I sat down elder asked "did you break my bed?" I replied back, "what do you mean?" She replied, "did you break my bed when you sat down?" I replied, "no, I'm not that heavy, why would you say that? She replied, "seem like you did." I told elder that was really rude of her to say, I haven't	F 600	the Quality Assurance Committee for review and evaluation to ensure consistence, substantial compliance is met, maintained and does not recur.	

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F 600	Continued From page 4	F 600		

done anything to her. Elder's TV was still loud, so I yelled for her to cut it down, elder screaming "I am trying to but if you would move your fat ass out infront of my TV, I could." I told elder to keep any rude comments to herself, because its not nice and won't be tolerated. I proceeded to administer the first injection the 57 units of Levemir, Elder proceeded to yell out. I apologized and began to administer her sliding scale of 12 units. As I inject the SS (sliding scale), Elder yelled out again and started hitting me with her remote control. I told her to stop and took the remote control from her. I tried to cut the TV down but the remote stopped working. I turned the TV down manually from the TV itself and told the elder, until her attitude is better the TV will stay off. I removed any objects that the elder could possibly throw or push over and left. Call light within reach. Will cont (continue) to monitor." This note was authored and signed by Licensed Practical Nurse (LPN) #1.

On 04-30-2021 at 2: 30 PM, during an interview with the Administrator and Director of Nursing (DON), they both stated they were on the fence with what to do, so they had not let her work since the report and she had continued to be suspended. Both agreed the investigation had "holes in it" and she back tracked about the reason she removed the remote. One time LPN #1 stated it was to see if it was broken, the other time it was to punish the elder for her behaviors. The State Agency (SA) read the definitions of "willful", "mental abuse", "exploitation", and "misappropriation of resident property" from the facility's abuse policy, and both agreed what occurred fit all of those categories.

On 05-03-2021 at 9:30 AM, during an interview

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 05/04/2021

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F 600	Continued From page 5	F 600		

with the Executive Director and Administrator, the SA was informed they the facility had chosen to terminate LPN#1 after her suspension ended and had reported the LPN to the Board of Nursing (BON), based on her documentation of the event, and Resident #1's fear of her caring for her again.

On the morning of 05-03-2021, the SA received LPN#1's phone number and attempted to call her for an interview. She did not return my call throughout the duration of the survey.

A copy of the written statement from LPN#1 given during her questioning for the facility investigation was provided to the SA. The statement stated, " This nurse prepared (formal name) Resident#1's medication... After drawing up the insulin, I entered back into the room and sat on the edge of the bed. Elder looked at me and asked "Did you break my bed?" I replied "No, why would you say that? I'm not that heavy." Elder replied, "Oh seems like it." I asked the Elder to hold her left arm up to see the abdomen better. Elder said she couldn't hear me, while trying to turn the TV down. In an elevated voice, I asked the Elder to turn the volume down from 99. Elder replied, "I will if you would move your fat ass out of the way!" I told the Elder that she would feel a stick, and administered the insulin. Elder yelled out, I apologized and told her I don't mean to hurt her. I started administering the second injection and Elder yelled out again. Before I could apologize, the Elder started hitting me with her TV remote. I removed the remote from the Elder's hands and told her to please not hit staff. I tried to turn the TV down with no luck. The remote was broken. I put the remote on the dresser and unplugged the TV only to get the volume under control. I left the room and asked the Shahbaz to come back in the

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 05/04/2021

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 600	Continued From page 6	F 600		

room with me to see if they could help get the volume down. We plugged the TV back up, and the Shahbaz was able to manually turn the volume down. We left the room with the TV plugged up and the remote near the Elder."

The SA looked at a copy of the facility schedule, and neither Shahbaz who worked with LPN #1 that night was on the schedule during the survey. Neither Shahbaz returned a phone call to the SA. Written statements were received from the facility for both Shahbaz.

Shahbaz #1's written statement revealed, " I remember (formal name) LPN #1 telling me (resident's formal name) Resident #1 hit her with the remote. I don't remember going into her room until the end of the evening to check on her and she was asleep. I think it was the other girl who went in her room several times but I never went in her room the whole time until the end of my shift."

Shahbaz #2's written statement revealed, "I was in the back and when I came out (formal name) LPN#1 told me (formal name) Resident #1 hit her with the remote. She said she went in and asked her about the situation and (formal name) Resident #1 said she hit her. Resident #1 had the remote in her hand but she couldn't remember if the TV was on or off. Resident #1 wasn't upset she just told her several times throughout the evening she popped that nurse."

Neither of the Shahbaz statements indicated they went back into Resident #1's room with LPN#1 to "see if they could help get the volume down", or plug the TV back up. Neither Shahbaz talked about going in the room and manually turning the volume down, or leaving the room with the nurse

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	255309	A. BUILDING _____ B. WING _____	C 05/04/2021

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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 600	Continued From page 7	F 600		

and the TV being plugged up and the remote near the resident

A written statement by Social Services, dated 04-23-2021, was provided regarding her interview with Resident #1. The statement revealed, "She sat on the bed so hard I though a piece had fallen off. My TV was on and loud. She asked me to turn it down. I realized it was not working because she was blocking the TV. She yelled again for me to turn down the TV. She gave me the shot in my rib area where it hurts, and I hit her in the arm with the remote. She grabbed the remote. She took my fingers off the remote. I heard a pop and it hurt real bad. I think it's fractured. She pointed her finger in my face stating "You are not going to do that again." I pointed my finger in her face and told her to get out of my room. She put the remote on the dresser where I could not reach it and unplugged the TV."

On 05-04-21 at 11:00 AM, during an interview with Social Services, she stated she went to interview Resident #1 because of a nurses note that was brought to her attention. She asked her about the remote situation, and Resident #1 was in a good mood that day. Elder told her very calmly that the nurse sat on the edge of her bed for an insulin shot, the TV was loud, so the nurse asked her to turn it down. She tried to turn it down, but the nurse's body was in the way. Resident #1 said she cussed her. The nurse gave the insulin shot in her rib cage area and it hurt so she hit her with the remote control. The nurse pried her fingers off the remote and took it from her. LPN #1 unplugged the TV and placed the remote on top of the TV and left the room.

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 05/04/2021

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CEDARS HEALTH CENTER	2800 WEST MAIN STREET TUPELO, MS 38801

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F 600	Continued From page 8	F 600		

Resident #9

Review of Resident #9's Face Sheet revealed, she was admitted to the facility on 04-13-2016 with diagnoses of Chronic Obstructive Pulmonary Disease, Pain in Left and Right Knee, Heart Failure, Hypertension, Osteoporosis, Atrial Fibrillation, Depression, Neonatal Cerebral Depression, Anxiety, Congestive Heart Failure, and Hard of Hearing.

Review of Resident #9's MDS, dated 03-15-2021, revealed, she is moderately hard of hearing, has a BIMS of 15, making her interviewable, required limited assistance of one staff for her adl's, and was frequently incontinent of bowel and bladder.

Review of the facility's investigation, dated 01-05-2021 revealed, that on 12-28-2020, Housekeeper #1 was witnessed "slinging a pack of diapers and cursing (formal name) Resident #9, and talking to her in a loud and menacing tone."

Review of a written statement from the eye witness, Shahbaz #3 revealed, "I came back in the building from Cedars and heard yelling and cursing going on. We saw the cleaner yelling, standing over (formal name) Resident #9. She was slinging a pack of diapers and cursing at (formal name) Resident #9 for accusing her of tampering with her things. Some things that were said were, "I don't have to steal out of your p**** a** room, I'm in my right mind, I don't play that sh**."

The SA attempted to reach Housekeeper #1, and there was no answer or answering machine to leave a message for a return call.

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 05/04/2021

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 600	Continued From page 9	F 600		

Shahbaz #3 had been terminated for "Job Abandonment" on 03-12-2021, prior to the survey. A message was left for her, with no return call to the SA.

On 04-30-2021 at 3:15 PM, during an interview with the Executive Director, she stated Shahbaz #3 was the one that reported the incident to her. She had no idea why Shahbaz #3 had waited eight (8) days to report it to her. She stated she had interviewed Housekeeper #1 but must not have written it down and put it in the folder. She stated the housekeeper didn't deny screaming at the Elder, but did deny that she cussed her out. When asked by the SA if there were other residents or staff interviewed to see if there was a pattern with the Housekeeper, and she stated, "Oh I know that we did, we just must not have written them all down. If there was something that was pertinent we would have made sure to put it in the folder with the investigation.

Record review of the Attorney General Report dated 1/5/21 revealed Housekeeper #1 was immediately suspended upon report and will be terminated.

On 05-03-2021 at 2:00 PM, during an interview with Resident #9, she stated she remembered that day and the housekeeper yelling at her, but she had not put in her hearing aides that day and didn't know what all she said. She knew that she had something in her hands but didn't remember what it was. She said she talked with the Executive Director because she had been told the housekeeper had been fired and she was afraid it was her fault. She said the Executive Director reassured her, she was not the reason she had to

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F 600	Continued From page 10 be let go. When asked by the SA if she was fearful or worried about staff being rough with her or using profanity around her she stated, "no, I'm not afraid to be here, the staff are good to me, and I'm sorry that young lady got fired."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		6/9/21

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 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 11 Based on staff interview and record review, the facility failed to timely report an incident of verbal abuse for one (1) of ten (10) residents reviewed for abuse, Resident #9. Findings Include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation", dated 01-25-2017, revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, and involuntary seclusion... 4. "Verbal Abuse" means the use of oral written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability... 9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the staff will: a. Respond to the needs of the resident and protect them from further incident (document). b. Notify the Director of Nursing and/or Administrator (document)... 10. The facility will comply with the following reporting requirements: a. Each covered individual shall report to the State Agency and one of more law enforcement entities for the political subdivision in which the facility is located, any responsible suspicion of a crime again any individual who is a resident of, or is receiving care from the facility. b. Each covered individual shall report immediately, but not later than 2 hours after forming suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result	F 609	1. An investigation was initiated on 01/05/21 with Housekeeper #1 being suspended and terminated on 01/06/21 by the Executive Director. Shahbaz #3 was re-educated on reporting allegations of abuse in a timely manner on 01/05/21 by the Executive Director. 2. All residents living in the Green House Home of the employee had the potential to be affected. The Executive Director interviewed the residents in the home with no other concerns identified on 01/025/21. 3. An education in-service was conducted on 01/05/21 with housekeeping staff on Resident Rights Abuse and Neglect and reporting allegations in a timely manner by the Executive Director. An acknowledgement from was form was created for employees to sign on 06/02/21 by the Administrator reiterating Cedars Health Center zero tolerance for any form of abuse and to report allegations immediately. 4. The Administrator and/or Director of Nursing will interview five employees for four consecutive weeks to verify understanding of current policy for reporting allegations of abuse/neglect/exploitation stating 06/09/21. Re-education will be provided at the time f the interview, if needed. Results of the interviews will be reported to the Quality Assurance Committee for review and evaluation to ensure consistent substantial compliance is met, maintained and does no recur.	

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 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 12	F 609		

in serious bodily injury."

Resident #9

Review of Resident #9's Face Sheet revealed, she was admitted to the facility on 04-13-2016 with diagnoses of Chronic Obstructive Pulmonary Disease, Pain in Left and Right Knee, Heart Failure, Hypertension, Osteoporosis, Atrial Fibrillation, Depression, Neonatal Cerebral Depression, Anxiety, Congestive Heart Failure, and Hard of Hearing.

Review of Resident #9's Minimum Datat Set (MDS), dated 03-15-2021, revealed, she is moderately hard of hearing, has a Brief Interview for Mental Status (BIMS) of 15, making her interviewable, required limited assistance of one staff for her ADL's, and was frequently incontinent of bowel and bladder.

Review of the facility's investigation, dated 01-05-2021 revealed, that on 12-28-2020, Housekeeper #1 was witnessed "slinging a pack of diapers and cursing (formal name) Resident #9, and talking to her in a loud and menacing tone."

Review of a written statement from the eye witness, Shahbaz #3 revealed, "I came back in the building from Cedars and heard yelling and cursing going on. We saw the cleaner yelling, standing over (formal name) Resident #9. She was slinging a pack of diapers and cursing at (formal name) Resident #9 for accusing her of tampering with her things. Some things that were said were, "I don't have to steal out of your pissy ass room, I'm in my right mind, I don't play that shit."

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F 609	Continued From page 13 Shahbaz #3 had been terminated for "Job Abandonment" on 03-12-2021, prior to the survey. A message was left for her, with no return call to the SA. On 04-30-2021 at 3:15 PM, during an interview with the Executive Director, she stated Shahbaz #3 was the one that reported the incident to her. She had no idea why Shahbaz #3 had waited eight (8) days to report it to her..." Review of Shahbaz #3's employee file revealed she had received in-servicing on abuse and reporting abuse upon hire via a signed document titled "Employee Acknowledgement Form" discussing a zero tolerance policy for abuse and neglect. Shahbaz #3 had signed and dated the document on 01-30-2019 upon her hire. She also signed a copy of "Resident's Rights" dated 01-30-2019.	F 609		