

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                          |                                                                    |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET</b><br><b>TUPELO, MS 38801</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                           | Initial Comments<br><br>The State Agency (SA) conducted a complaint survey, MS #16399 on 11/25/19. During the survey, the SA substantiated MS #16399, related to a facility reported incident for misappropriation of property. The SA determined the facility was not in substantial compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statute M500.<br><br>The facility had a census of 134 at the time of the complaint survey, with a license for 140 beds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | M 000                                                                                            |                                                                                                                          |                                                                    |
| M 500                                                           | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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;<br><br>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;<br><br>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 contraindicated (as documented by a physician or | M 500                                                                                            |                                                                                                                          | 1/10/20                                                            |

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/16/19

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                          |                                                                    |
|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET</b><br><b>TUPELO, MS 38801</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 500                                                           | <p>Continued From page 1</p> <p>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;</p> <p>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;</p> <p>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;</p> <p>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial</p> | M 500                                                                                            |                                                                                                                          |                                                                    |

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                            |                                                                                                                          |                                                                    |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET<br/>TUPELO, MS 38801</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 500                                                           | <p>Continued From page 2</p> <p>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;</p> <p>7. is free from mental and physical abuse;</p> <p>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;</p> <p>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;</p> <p>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;</p> <p>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;</p> <p>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,</p> | M 500                                                                                      |                                                                                                                          |                                                                    |

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                          |                                                                                                                                                                                                                |                          |                                                                    |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                         |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET<br/>TUPELO, MS 38801</b>                                                                                                                     |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                       | (X5)<br>COMPLETE<br>DATE |                                                                    |
| M 500                                                           | <p>Continued From page 3</p> <p>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);</p> <p>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);</p> <p>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);</p> <p>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</p> <p>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.</p> <p>This Statute is not met as evidenced by:<br/>Level II</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to</p> | M 500                                                                    | <p>M 500--- The facility will safeguard that residents are free from misappropriation:<br/>Resident # 1 was assessed by the Registered Nurse (RN) on November 2, 2019 for any complications related to the</p> |                          |                                                                    |

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                    |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET<br/>TUPELO, MS 38801</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X5)<br>COMPLETE<br>DATE                                           |
| M 500                                                           | <p>Continued From page 4</p> <p>ensure one (1) of four (4) residents reviewed, was protected from misappropriation, Resident #1.</p> <p>Findings include:</p> <p>Review of the facility's "Abuse, Neglect and Exploitation" policy, dated 1/25/17, revealed: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.</p> <p>Review of the facility's report and investigation, dated 11/4/19, revealed on 11/2/19, Resident #1 reported \$60 and her Green Dot card, missing from her wallet, after returning from the dining room. Upon review of video surveillance, from 11/2/19, the video footage revealed CNA #1 was seen entering Resident #1's room at 12:10 PM, after Resident #1 and her sister left to go to the dining. At 12:12 PM, CNA #1 was seen exiting the resident's room. Further review of the video revealed, Resident #1 returned to her room at 12:40 PM, remained in her room the rest of the day and no staff entered her room unattended. CNA #1 was suspended pending the outcome of the investigation. The facility refunded Resident #1 \$60 in cash and the debit card was deactivated, with no charges made to the card. An addendum to the the facility's report, revealed the Administrator contacted CNA #1 via telephone and terminated her for this incident.</p> <p>Review of a typed statement, dated 11/2/19, and signed by Registered Nurse (RN) #1, documented she was notified by the floor nurse, Resident #1 had reported money was stolen from</p> | M 500                                                                                      | <p>incident and no psychosocial harm was found. The RN reported the incident to the Administrator and DON. The facility replaced the elder's money on November, 12, 2019.</p> <p>All elders living at Cedars had the potential to be impacted by the stated deficient practice.</p> <p>All elders at Cedars were interviewed by the Social Worker on November 4, 2019 and no negative findings were found. All employees of Cedars were in-serviced on November 11, 2019 by the Director of Nursing on Abuse, Neglect, Exploitation and Misappropriation of Funds. All Department Directors, RN Coordinators, Quality Assurance Nurse, Activities, Restorative Nurse, Director of Nursing, Dietary, Therapy, Minimum Data Set Nurses, and Certified Nursing Assistants (CNAs) were in-serviced on 12/2/19 by the Administrator and Assistant Administrator on Abuse, Neglect, Exploitation and Misappropriation of Funds. All employees were in-serviced on Abuse, Neglect, and Exploitation by 12/6/19. A Dementia Training and Mental Health In-service was provided by a Certified Mental Health professional and offered to all staff on 12/4/19.</p> <p>The Interdisciplinary Team will discuss daily Monday-Friday if misappropriation or missing items have been reported in their stand-up meeting. Beginning December 13, 2019, the Social Worker will interview five (5) elders weekly for four (4) weeks, then monthly for six (6) months. This will be incorporated into our Quality Assurance Performance Improvement Plan.</p> |                                                                    |

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                            |                                                                                                                                                                                                                                                                                |                                                                    |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET<br/>TUPELO, MS 38801</b> |                                                                                                                                                                                                                                                                                |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                       | (X5)<br>COMPLETE<br>DATE                                           |
| M 500                                                           | <p>Continued From page 5</p> <p>her purse. RN #1 documented she took a statement from Resident #1, with the floor nurse present. Resident #1 reported her sister had visited, and had lunch with her on the day of the incident, and had given her a \$10 bill. Resident #1 further reported having \$50 cash in her wallet, with several coins amounting to another \$10. Resident #1 reported she left her purse in a recliner and covered it with a jacket, when she and her sister left the room to eat lunch. RN #1 documented when Resident #1 returned from lunch, she discovered the cash in her wallet, the coins, and her Green Dot debit card was missing. RN #1 documented she notified the Administrator and reported the incident.</p> <p>During an interview and observation, on 11/25/19 at 9:40 AM, Resident #1 was noted to be alert and oriented. Resident #1 stated she had \$60 taken from her wallet a few weeks ago. She confirmed the facility replaced the money.</p> <p>An interview with the State Investigator, from the Attorney General's (AG) office, on 11/26/19 at 9:30 AM, revealed when the AG's office conducted their investigation, CNA #1 confirmed by phone, she had taken the money from Resident #1's wallet, while Resident #1 was out of her room.</p> <p>The State Agency (SA) was unable to reach CNA #1 by phone during the SA's visit on 11/25/19.</p> <p>Record review of CNA #1's employee file/in-service records, revealed CNA #1 was hired on 03/15/18, and signed a policy regarding Abuse, Neglect, Exploitation, and Resident Rights on 03/21/18.</p> <p>Review of the facility's in-services titled, "Abuse</p> | M 500                                                                                      | <p>This plan of correction will be monitored weekly at the Quality Assurance Performance Improvement (QAPI) meeting until such time consistent substantial compliance has been reached. Recommendations and changes will be made as needed during the QAPI review process.</p> |                                                                    |

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                                                                                          |                          |                                                                    |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>41CH</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS HEALTH CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2800 WEST MAIN STREET</b><br><b>TUPELO, MS 38801</b>                         |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| M 500                                                           | Continued From page 6<br><br>and Neglect", dated 10/26/18 and 2/13/19,<br>revealed CNA #1 documented her signature, as<br>being in attendance.<br><br>Review of the Face Sheet, revealed, Resident #1<br>was admitted by the facility on 10/25/19, with<br>diagnoses, which included Chronic Obstructive<br>Pulmonary Disease and Major Depressive<br>Disorder.<br><br>Review of Resident #1's Minimum Data Set<br>(MDS) with an Assessment Reference Date<br>(ARD) of 10/31/19, revealed Resident #1 had a<br>Brief Interview for Mental Status (BIMS) score of<br>15, which indicated Resident #1 was cognitively<br>intact. | M 500                                                                    |                                                                                                                          |                          |                                                                    |