

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255309		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/10/2020	
NAME OF PROVIDER OR SUPPLIER CEDARS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 investigating MS CI 00016448, MS CI 00016477 and MS CI 00016462 on 01/08/20 to 01/10/20. Concerns identified in the complaint # 16448 were related to a facility reported incident of alleged abuse/neglect for Resident #1. These concerns were not substantiated, and no deficiencies were cited. Concerns identified in the complaint # 16477 was an allegation of neglect and quality of care for Resident #4. These allegations were unable to be substantiated by the state agency and no deficiencies were cited. Concerns identified in the complaint # 16462 were allegations of neglect related to pressure sores for Resident #11. These allegations were not substantiated by the state agency and no deficiencies were cited. During the survey the SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 132 at the time of the complaint survey, with a license for 140 bed capacity.			F 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.