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 _____	02/13/2020

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 an annual recertification survey at the facility from 02/10/2020 to 02/13/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations of participation. The SA cited deficiencies at F645, F656, F658, and F812. At the time of survey, the facility was licensed for 140 beds, and had a census of 133.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		3/13/20

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

Electronically Signed | 03/27/2020

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.

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F 645	Continued From page 1 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 645		

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F 645	Continued From page 2 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately screen a resident on a Pre-Admission Screening (PAS) application for one (1) of 33 sampled residents, Resident #124. Findings include: Review of the facility's "Resident Assessment - Coordination with PASARR Program" policy, dated 11/2019, revealed: "This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs." A review of Resident #124's" Pre-Admission Screening (PAS) Application for Long Term Care", dated 01/15/2020, revealed under Section IX - Level II Determination, was marked "no" for criteria statement "person has diagnosis of Alzheimer's Disease or other Dementia." The PAS application also revealed, "no" was marked to the Level II Referral criteria statement "person has a diagnosis of a major mental illness" and "person takes or has a history of taking psychotropic medication(s)." Review of Resident #124's medical record, revealed he was admitted by the facility on 01/14/2020, with diagnoses which included Dementia with Behavioral Disturbance, Major	F 645	This plan of correction is in response to Statement of Deficiencies, demonstrates our good faith and desire to continue to improve the quality of care and services provided to our elders. The facility will ensure that elders receive an accurate screen on a Pre-Admission Screening (PAS) application when admitted to facility. Resident number one hundred and twenty-four was admitted to Green House 900 on 01/14/2020. The Admission's Coordinator was in-serviced 02/13/2020 by the Administrator on the policy and procedure for completing the Pre-Admission Screening and Resident Review (PASRR) to ensure accuracy that the appropriate diagnosis was selected for that elder. Administrator also in-serviced License Social Workers and Minimum Data Set (MDS) nurses on the policy and procedure for completing the PASRRs. The PASRR Screening was resubmitted for Resident #124 on 02/13/2020 by Admission's Coordinator. Resident #124 was reviewed for a level II evaluation by Ascend on 02/14/2020 that revealed nursing facility placement is appropriate for elder. All elders have the potential to be impacted by the deficient practice. Beginning 02/14/2020, after the Admissions Coordinator completes a	

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F 645	Continued From page 3 Depressive Disorder, Anxiety Disorder, and Psychosis Not Due to a Substance or Known Physiological Condition. Review of the February 2020 physician orders for Resident #124, revealed orders for the following psychotropic medications: Olanzapine 5 milligram (mg) tablet one tablet by mouth (PO) every night for Dementia with behavioral disturbances, with an order date of 01/14/2020, Ativan 0.5 mg tablet one tablet by mouth every 4 hours as needed (PRN) for 14 days due to Anxiety, with an order date of 01/29/2020 and stop date of 02/12/2020; and Sertraline HCL 25 mg tablet give one and a half tablet (to total 37.5 mg) by mouth daily due to Depression, with an order date of 01/14/2020. A review of Resident #124's Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/22/2020, revealed Section N (Medications) was coded to reflect the resident received an antipsychotic and antidepressant medication for seven (7) days, and received an antianxiety medication for 6 days; during the 7 day look back period. During an interview, on 02/13/2020 at 11:43 AM, the facility's Admission Coordinator stated she was responsible for completing the Pre-Admission Screening (PAS) Application for Long Term Care. She stated Resident #124 had a diagnosis of Dementia and Major Mental Illness and was receiving psychotropic medications upon admission to the facility. The Admission Coordinator confirmed the PAS application was inaccurately filled out and submitted.	F 645	PASRR on all new admissions, then License Social Worker or MDS Nurse will review the PASRR and will complete PASRR audit form to ensure the accuracy of all diagnosis and medications were selected for that patient. The Director of Nursing (DON) reviewed all PASRRs that were completed on all new admissions beginning 02/14/2020 for one week and then DON reviewed PASRRs on five new admissions weekly on Fridays for three weeks. On 3/12/2020, the auditing reports were reviewed by the Quality Assurance Committee to ensure substantial compliance has been achieved as determined by the committee. Beginning 4/12/2020, DON will review all PASRRs that were completed on all new admissions monthly for six months to ensure accuracy. The DON will report the results of the monthly PASRR audits on all new admissions at the Quality Assurance Performance Improvement monthly meetings. These results and this Plan of Correction will be monitored monthly at the Quality Assurance Performance Improvement meetings for six months until such time consistent substantial compliance has been achieved.	

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F 645	Continued From page 4 During an interview on 02/13/20 at 02:25 PM, Director of Nursing (DON), confirmed the facility failed to submit the PAS accurately. The DON stated accuracy is important for proper placement and care for the resident.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/13/20

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F 656	Continued From page 5 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to develop a care plan for Activities, for two (2) of 29 care plans reviewed, Resident #85 and #91. Findings include: Review of the facility's "Comprehensive Care Plans" policy, dated 2017, revealed, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Resident #85 Review of the comprehensive care plan for Resident #85, revealed there was not a care developed for Activities.	F 656	The facility will ensure that all elders will a have care plan developed for activities. The Activity Director developed an Activity care plan for Resident number eighty-five and Resident number ninety-one on 02/11/2020. The Activity Director was immediately in-serviced 02/11/2020 by the Administrator on the Comprehensive Care Plan policy. The Minimum Data Set (MDS) nurses were also in-serviced on 02/14/2020 by administrator on the policy of developing Comprehensive Care Plans. The Activity Director developed an Activity care plan for Resident #85 and Resident #91 on 02/11/2020. All elders have the potential to be impacted by the deficient practice. The MDS Nurse/Activity Director are responsible for developing Comprehensive Care Plans on all new admissions beginning 02/14/2020. MDS Nurse reviewed all of the current elder's care plans by 02/21/2020 to ensure that an activity care plan was developed. The Director of Nursing (DON) reviewed all	

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F 656	Continued From page 6 A review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/25/2019, revealed Section F (Preferences for Customary Routine and Activities) was completed by staff. The staff assessment indicated the resident preferred listening to music and participating in religious activities or practices. Review of the Brief Interview of Mental Status (BIMS), revealed Resident #85 had a score of 15, which indicated intact cognitive status. On 02/11/2020 at 9:49 AM, during an interview with Resident #85, she stated "I just stay to myself." Resident #85 revealed that the facility will sometimes have something fun to do like Bingo, but not all the time. During an interview, on 02/12/2020 at 3:30 PM, the Director of Nursing (DON) confirmed there was not an Activities care plan for Resident #85. The DON revealed, the Activity Assistant was off on medical leave, and Resident #85 was one of their newer residents. The DON stated the Activity Director was working by herself and must not have gotten it done yet. A review of the facility's "Face Sheet" revealed, Resident #85 was admitted by the facility on 12/18/2019, with diagnoses which included Diabetes Type 2, Major Depression, Anxiety Disorder, Pain, and Hypertension. Resident #91 A review of Resident #91's comprehensive care plan, revealed there was no Activities care plan present.	F 656	Activity Care Plans that was completed upon admission on new elders beginning 02/14/2020 for one week and then DON reviewed Activity Care Plans on five new admissions every Friday for three weeks. On 3/12/2020, the auditing reports were reviewed by the Quality Assurance Committee to ensure substantial compliance has been achieved as determined by the committee. Beginning 4/12/2020, DON will review all Activity Care Plans that were completed on all new admissions monthly for six months. DON will report the results of the monthly Activity Care Plan audits on all new admissions to the communities of the Quality Assurance Performance Improvement monthly meetings. These results and this Plan of Correction will be monitored monthly at the Quality Assurance Performance Improvement meetings for 6 months until such time consistent substantial compliance has been achieved.	

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F 656	Continued From page 7 Review of the Admission MDS Assessment, with an ARD of 01/15/2020, revealed Section F (Preferences for Customary Routine and Activities) indicated Resident #91 activities that were very important to her included: having books, newspapers and magazines to read, listening to music, being around animals, keeping up with the news, doing favorite activities, going outside to get fresh air when the weather was good and participating in religious activities or practices. Review of the Brief Interview of Mental Status (BIMS), revealed Resident #91 had a score of 11, which indicated moderate cognitive impairment. On 02/11/2020 at 10:14 AM, during an interview with Resident # 91, she stated, "I kind of stay in my room, because a lot of noise bothers me. I just watch TV, I guess." An interview with the DON, on 02/12/2020 at 3:30 PM, confirmed there was no Activities care plan for Resident #91. A review of facility's "Face Sheet", revealed Resident # 91 was admitted on 01/08/2020, with diagnoses which included Major Depression, Anxiety, Hypothyroidism, and Age-related Osteoporosis.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		3/13/20

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F 658	Continued From page 8 by: Based on observation, staff interview, and manufacturer's recommendation the facility failed to instruct the resident to rinse her mouth after use of a steroid inhaler, for one (1) of two (2) residents observed receiving an inhaled medication during medication pass, Resident #127. Findings include: Review of the facility's "Administration of Metered Dose Inhalers" policy, dated 01/08/2018, revealed: "Rinse mouth when required per manufacturer recommendations or according to standards of practice." A review of the manufacturer's recommendations for Symbicort 160-4.5 mcg, revealed: "After inhalation, the patient should rinse the mouth with water without swallowing." During an observation, on 02/11/2020 at 9:00 AM, Licensed Practical Nurse (LPN) #1 administered Symbicort 160-4.5 micrograms (mcg) to Resident #127, giving two puffs/inhalations by mouth. LPN #1 did not provide a cup of water for the resident to rinse her mouth and spit after the inhaler use as per manufacturer's recommendations. LPN #1 exited the resident's room and returned to the medication cart. An interview with LPN #1, on 02/11/2020 at 9:05 AM, revealed, she knew the routine. LPN #1 asked, "Should I have to remind her to rinse her mouth every day when she uses the inhaler?" LPN #1 confirmed she did not provide a cup of water to the resident for her to rinse her mouth and spit, and stated she would take the resident	F 658	The facility will ensure that all Licensed Nursing Staff will provide a cup of water to all elders that receive an inhaled medication to remind elders to rinse their mouth after use of inhaler. Licensed Practical Nurse (LPN) number one was immediately in-serviced 02/11/2020 by the Director of Nursing (DON) on the policy for administration of a metered dosed inhaler. The DON in-serviced all Licensed Nursing Staff on the policy for administration of an inhaled medication by 02/18/2020. All elders who receive inhaled medication have the potential to be impacted by deficient practice. The DON will complete skilled check offs on five nurses who administers inhaled medications to elders for one week beginning 2/19/2020, then will check off three nurses every week for three weeks. On 3/12/2020, the auditing reports were reviewed by the Quality Assurance Committee to ensure substantial compliance has been achieved as determined by the committee. Beginning 04/12/2020, DON will complete a skilled check off on a nurse administering inhaled medications every week for 6 months to ensure proper administration of an inhaled medication. DON will report the results of the monthly inhaled medication skilled check off on nurses to the communities of the Quality	

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F 658	Continued From page 9 some water back to her room if she needed to. A review of LPN #1's "Licensed/Registered Nurse Competency," dated 10/07/2019, revealed she received training in Medication Management , which included Respiratory medications. Review of the facility's "Face Sheet", revealed, Resident #127 was admitted by the facility on 08/14/2018, with diagnoses which included, Acute and Chronic Respiratory Failure and Unspecified Dementia with Behavioral Disturbances. A review of the most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/03/2020, revealed Resident #127 had a score of 14 on the Brief Interview for Mental Status (BIMS), which indicated intact cognitive ability.	F 658	Assurance Performance Improvement monthly meetings. These results and this Plan of Correction will be monitored monthly at the Quality Assurance Performance Improvement meetings for 6 months until such time consistent substantial compliance has been achieved.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/13/20

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F 812	Continued From page 10 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to maintain a safe and sanitary dietary environment, as evidenced by, unclean ovens, dirty food bins, scoops left in the food bins, and expired foods, for three (3) of 11 kitchens observed. Review of the facility's policy, "Sanitizing Ingredient Bins - #4054" undated, revealed: "Ingredient bins will be sanitized on a regular basis." Review of the facility's "Cleaning Ovens - #4079" policy, undated, revealed: "Ovens will be cleaned and sanitized on a regular basis." A review of the facility's "Food Storage and Handling" policy, undated, revealed, it is the policy of the Dining Services Department to cover, label, date, and store all foods in a safe, appropriate manner for the purpose of preventing food borne illnesses. All dry, refrigerated, and frozen items are stored six (6) inches above the floor and not more than 18 inches from the ceiling, in a temperature controlled room. Dry bulk items, such as rice, sugar, and flour are stored in seamless containers with tight fitting lids and are clearly labeled. Scoops should not be left in food bins. On 02/10/2020 at 10:32 AM, an observation, during initial tour of the kitchen, revealed three (3) large plastic bins containing flour, meal and sugar. There were scoops observed in the meal	F 812	The facility will maintain a safe and sanitary dietary environment. On 02/11/2020, all expired or non-labeled/dated foods were removed from the Green Houses by the Green House Guide. On 2/10/2020, the ovens were cleaned by Dining Staff. On 02/10/2020, the food bins were emptied and cleaned as well as the scoops were disposed of and new scoops were purchased by the Dietary Manager. All dietary staff and Shahbaz were in-serviced on 02/11/2020 and 02/12/2020 by the System Executive Chef and General Manager on labeling and dating food, proper storage of dry foods, and proper cleaning of the ovens. This facility has determined that all elders are at risk for the deficient practice. Beginning 02/14/2020, the Registered Dietician, Systems Executive Chef, Dining Director, Certified Dietary Manager, Executive Chef, and the District Manager will provide weekly audits of the kitchens to ensure proper storage of foods and cleanliness of the ovens. On 3/12/2020, the auditing reports were reviewed by the Quality Assurance Committee to ensure substantial compliance has been achieved as determined by the committee.	

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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 812	Continued From page 11 and flour bins, and a small metal bowl turned upside down in the sugar. The tops and inner edges of the bins had yellowish, brown dry material and crumbs on them. The Dietary Director (DD) removed the scoops from the bins, and the Dietary Manager (DM) removed the small metal bowl from the sugar bin. During an interview, on 02/10/2020 at 10:35 AM, with the Dietary Manager (DM), she stated all of the items were contaminated, and would have to be discarded because the scoops should not be left in the bins. The DM confirmed the bins were dirty and needed to be cleaned. On 02/10/2020 at 10:45 AM, an observation of the convection oven, revealed inside of the oven door, walls, and racks were coated with brown, sticky material and drips of black material hanging from the rack. The bottom of the oven and door opening, contained brownish dry spills, food crumbs and debris. On 02/10/2020 at 10:47 AM, an observation of the two (2) ovens under the range, revealed the walls, inside of the doors, and racks were coated with brown and black build-up. The bottom of both ovens had brownish-black build-up, crumbs and black debris on the floor, shelf ledges, and door crevices. An observation and interview on 02/10/20 at 10:50 AM, with the Dietary Director (DD), confirmed the condition of the convection oven and range ovens. The DD stated they were horribly dirty and embarrassing. He stated the build-up on the ovens could be the cause of a fire, and the black stuff hanging off the racks could cause contamination of foods.	F 812	The General Manager/Registered Dietician will report the results of the weekly audits of the kitchens to the communities of the Quality Assurance Performance Improvement monthly meetings. These results and this Plan of Correction will be monitored monthly at the Quality Assurance Performance Improvement for six months until such time consistent substantial compliance has been achieved.	

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 _____	02/13/2020

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 812	Continued From page 12 An interview, on 02/12/2020 at 9:45 AM, with the Registered Dietician (RD) revealed the facility started with a new company the first of the year, and they had not gotten the new schedules in place for cleaning, but that was no excuse for the dirty ovens and bins. On 02/10/2020 at 11:45 AM, during an initial tour of House #3 and interview with Certified Nurse Aide (CNA) #1, the following items were observed opened and undated: - 1 bag of "Cheerios" - 1 box of Yellow Cake Mix - 1 box of Devil Food Cake - 1 bag of vanilla wafers - 1 bag of white flour - 1 bag of orange jello - A large bin of potatoes 2-3 inches off the floor CNA #1 stated they are suppose to be putting those orange labels on stuff that is opened and doesn't get used up. CNA #1 revealed items are supposed to be dated so they would know when it goes bad. On 02-10-2020 at 12:30 PM, during initial tour in House #4, and interview with CNA #5, the following items were observed opened and undated: - 1 bag of "Cheerios" - 2 bags of coffee - 1 bag of pecans CNA #5 stated that sometimes the girls get in a rush to get things prepped and cooked, and they forget to put the labels on stuff right. CNA #5 revealed that she tries to watch for those things, but must have missed a few.	F 812		

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 _____	02/13/2020

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 812	Continued From page 13 During an interview with the Director of Nursing (DON) on 02/12/2020 at 3:00 PM, she stated, they (Shabazz) are supposed to label everything they open, unless it is all used up. The DON stated, someone could really get sick, if certain food items are past their edible date.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **02 - CEDARS HEALTH CARE GREENHOUSES 01** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 03/27/2020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire doors as required by S&C Letter 17-38. This deficiency practice affected one (1) of two (2) smoke compartments and 14 of 60 residents in the facility on the day of survey. Findings include: On 2/14/2020 at 9:15 AM, observation revealed one (1) fire doors in the facility. The facility could not provide documentation showing the annual inspection of the fire doors in the facility. The one (1) set of fire doors were located Therapy Area of the facility.	K 211	1. Fire doors were inspected by a certified fire door inspector on 2/25/20. Documentation was provided and filed. 2. All fire doors in facility were inspected as required. 3. Cedars maintenance staff will conduct inspection of all fire doors monthly and document. 4. Annual fire door inspection was added to maintenance software to insure it is scheduled to be performed as required and documentation will be filed.	3/13/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **03 - CEDARS HEALTH CARE GREENHOUSES 02** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **04 - CEDARS HEALTH CARE GREENHOUSES 03** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **05 - CEDARS HEALTH CARE GREENHOUSES 04** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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	255309	A. BUILDING **06 - CEDARS HEALTH CARE GREENHOUSES 05** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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	255309	A. BUILDING **07 - CEDARS HEALTH CARE GREENHOUSES 06** B. WING _____	**02/14/2020**

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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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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	255309	A. BUILDING **08 - CEDARS HEALTH CARE GREENHOUSES 07** B. WING _____	**02/14/2020**

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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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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	255309	A. BUILDING **09 - CEDARS HEALTH CARE GREENHOUSES 08** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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	255309	A. BUILDING **10 - CEDARS HEALTH CARE GREENHOUSES 09** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING **11 - CEDARS HEALTH CARE GREENHOUSES 10** B. WING _____	**02/14/2020**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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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 _____	02/14/2020

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
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/14/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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