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 _____	04/13/2023

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 and a complaint investigation (CI MS #21294) at the facility from 4/11/23 through 4/13/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F558, F644, F729 and F880. The SA found the facility to be in compliance related to (CI MS #21294) and no deficiencies were cited. The census at the time of the survey was 130 and the facility was licensed for 140 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		5/17/23

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

Electronically Signed | 04/27/2023

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to promote and maintain the dignity of a resident as evidenced by a urinary catheter bag with no privacy bag for one (1) of four (4) residents reviewed with a urinary catheter. Resident #115 Findings Include: Record review of the facility policy titled, "Promoting/Maintaining Resident Dignity" with a revision date of 10/2022 revealed "Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality ....12. Maintain resident privacy ..."	F 550	1. The resident's urine bag was covered on 4/12/23, and the certified nursing assistants caring for resident #115 were in-serviced by the Administrator and the Green House Guides (lead Certified Nursing Assistants) on proper procedures for covering catheter bags. 2. The facility determined that all residents requiring a catheter had the potential to be affected. An MD order list was printed to identify those residents with a catheter. 3. Those residents with a catheter were rounded on to ensure the catheter was covered on 4/12/23 by the Green House Guide. An in-service was initiated on 4/12/23 by the administrator for certified nursing assistants and licensed nursing personnel regarding promoting dignity by ensuring all catheter bags were covered.	

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F 550	Continued From page 2 Record review of a typed statement dated April 12, 2023 and signed by the Administrator revealed "We do not have a specific policy on covering catheter bags." An observation on 04/11/23 at 3:48 PM, revealed Resident #115 sitting in the day room of the (Proper name) building on the sofa with his urinary catheter bag hanging off the front of the sofa with no cover over the urine bag that was full of urine. An interview on 4/12/23 at 12:05 PM, with the Director of Nurses (DON) confirmed that residents with urine catheter bags should have a privacy bag covering their urine catheter bag for the resident's dignity. She revealed that the facility has blue privacy bags, and the staff are aware they should always put a privacy bag over the urine catheter bag based on an understood policy. An interview on 4/12/23 at 3:15 PM, with the Administrator confirmed that it is an understood policy that urine catheter bags should be covered with a privacy bag regarding dignity for the resident. Record review of Resident #115's Order Summary Report revealed an order dated 3/15/23, "Indwelling Foley catheter in place due to neurogenic bladder..." Record review of Resident #115's Admission Record revealed the resident was admitted to the facility on 03/14/23 with medical diagnoses that included Retention of urine and Vascular dementia, unspecified severity.	F 550	The clinical educator will complete this training by 5/9/23. 4. The Director of Nursing, Green House Guide, and Administrator will conduct observation of the elders with catheter bags weekly times four weeks starting 4/17/23 and monthly times 3 months to ensure staff are promoting and maintaining residents right to dignity by keeping the urine bag covered. These observation audits will be brought to the Quality Assurance and Performance Improvement Plan Committee (QAPI) meeting on 5/17/23, for review and recommendations monthly until such a time consistent substantial compliance has been achieved as determined by the committee.	

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F 550	Continued From page 3 Record review of Resident #115's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/23 revealed in "Section H" that the resident has an indwelling catheter and in "Section C" a Brief Interview for Mental Status (BIMS) score of 05, which indicated the resident is severely cognitively impaired.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review the facility failed to provide a resident with an appropriately sized wheelchair for one (1) of 32 residents reviewed. Resident #107 Findings include: Record review of a typed statement dated April 12, 2023 and signed by the Administrator revealed "We do not have a policy on Wheelchair Sizing. There is a protocol that therapy follows but not a written policy." An observation on 04/11/23 at 4:45 PM, revealed Resident #107 sitting in her wheelchair in the dayroom, complaining that her wheelchair was too big for her, and she has told people, but they think it is fine. This observation revealed there	F 558	1. Resident #107 was assessed by the Rehabilitation Director on 4/12/23 for the proper size wheelchair. The facility purchased a new wheelchair on 4/12/23 for resident #107. The certified nursing assistants caring for resident #107 were educated on the importance of providing the proper size wheelchair to ensure accommodations of the residents needs by the Administrator and the Green House Guides on 4/12/23. 2. The facility determined that all residents requiring a wheelchair have the potential to be affected. 3. The Rehabilitation team assessed all residents requiring wheelchairs in the Green Houses on 4/13/23 to ensure they were placed in the appropriately sized chair to accommodate their needs. The	5/17/23

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F 558	Continued From page 4 was 2-4 inches of space on the seat on either side of the resident between her hips and the wheelchair arms. Her arms were stretched over the arms of the wheelchair with only her fingers reaching the self-propel wheels and she was using her tiptoes to push her wheelchair. This observation revealed she was not able to put her feet flat on the floor unless she scooted to the front edge of the wheelchair seat. An interview on 4/12/23 at 2:30 PM, with the Rehabilitation (Rehab) Director revealed that new admissions are provided a wheelchair and that the resident is evaluated on the same day of admission or the next day to make sure the wheelchair size is correct. She stated that the resident's wheelchair should allow the resident's feet to sit flat on the floor while sitting in the wheelchair and should have 1-2 inches of space between the resident's side of hip and the arm of the chair. An interview on 4/12/23 at 3:40 PM, with the Rehab Director confirmed that Resident #107's wheelchair was too big for her body size. She confirmed that she went and evaluated the chair size and determined that the chair was an 18 inch and the resident needed a 16-inch chair and needs some of the height taken off, so that the resident's feet can be flat to the floor. She stated that with the resident's wheelchair being too big could cause the self-propelling of the wheelchair not to be easy and she then stated that we want it to be easy for them. An interview on 4/12/23 at 4:30 PM, with the Administrator confirmed that Resident #107 should not have had a wheelchair that was too big for her. She revealed that she does not	F 558	chairs were discreetly labeled to ensure that the staff could identify which chair belonged to each resident. An in-service was initiated on 4/12/23 by the administrator for certified nursing assistants and licensed nursing personnel on the importance of providing the appropriately sized wheelchair to ensure appropriate accommodation of the residents needs. The clinical educator will complete this training by 5/9/23. 4. The Director of Nursing, Rehabilitation Director, and Registered Nurse Clinical Coordinator will conduct 10 observations of residents wheelchairs weekly times four weeks so ensure staff are providing the appropriately sized wheelchairs in accordance with our facility's practice beginning 4/17/23, then monthly x 3 months. Results of the observations will be reviewed by the Quality Assurance and Performance Improvement Committee (QAPI) on 5/17/23, and monthly thereafter until such a time consistent substantial compliance has been achieved as determined by the committee.	

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F 558	Continued From page 5 understand why one of the Registered Nurses RN's or Shabazz's (Certified Nursing Assistants) had not already mentioned it to someone. Record review of Resident #107's Admission Record revealed the resident was admitted to the facility on 02/06/23 with medical diagnoses that included Muscle Weakness. Record review of Resident #107's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/23 revealed in Section C a Brief Interview for Mental Status of 05, which indicates the resident is severely cognitively impaired and in "Section G" that the resident uses a wheelchair.	F 558		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every	F 729		5/17/23

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F 729	Continued From page 6 State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure that a Certified Nurse Assistant (CNA) maintained an up-to-date certification for one (1) of 115 certifications reviewed. Finding include: Review of the facility policy titled, "License Verification", dated 10/2022 revealed all personnel that require a license or certification shall be verified through the appropriate issuing agency. The Human Resources Director, or designee, is responsible for maintaining and ensuring the validity and current status of individual certification/licensure. Any licensed /certified employee is responsible for submitting verification of licensure/certification renewal to Human Resources prior to expiration. Record review of the Certified Nursing Assistant (CNA) certifications revealed CNA #1 did not have an up-to-date certification on file. A copy of	F 729	1. Certified nursing assistant #1 was removed from direct care on the schedule on 4/13/23 by the Green House Guide. Certified nursing assistant #1 was assisted in creating an account to begin the renewal process. A three step application was submitted to request a one-time challenge to the certified nursing assistant test to become recertified. If certified nursing assistant #1 has not been recertified, she will be registered to attend the certified nursing assistance program at the local community college starting May 8, 2023. 2. All residents were identified as having the potential to be affected. 3. An active employee list was reviewed with the current payroll data and licensure websites to ensure that all staff providing care for the residents license were current by the administrator on 4/13/23. All current and newly hired employees, requiring license/credential data, will be	

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F 729	Continued From page 7 the certification revealed it expired on 1/31/2023. An interview on 4/13/23 at 11:15 AM, with the Administrator (ADM) confirmed the CNA #1's certification was not up to date in the employee folder and the CNA had been working at the facility since her certification had expired. She stated she works full time 11/7 shift in one of the Greenhouses. She stated there had been no issues reported regarding the care given by CNA #1. The ADM stated a double check of licenses and certifications should be done with a spread sheet of up-to-date employees from their payroll system. The ADM confirmed that CNA #1 would not be working as a certified nursing assistant until her certification was renewed. An interview on 4/13/23 at 11:20 AM with the Human Resources Manager revealed she was responsible for keeping track of the CNA certifications. She stated that she goes by her binder, but CNA #1's certification was not in the binder and that she does not do a double check using a list of employees. Record review of CNA #1's certification from the Mississippi Nurse Aide Registry revealed Status-Inactive and an Expiration Date 01-31-2023. Record review of CNA #1's payroll information revealed she had worked five days from March 20, 2023, through April 02, 2023.	F 729	entered into the Kronos payroll system so monthly reports can be pulled from the system to ensure timely licensure renewal. All current credentialing information will be entered into the payroll system by the Human Resources Manager by 5/09/23 and verified as correct by the administrator by 5/10/23. The Human Resource Manager was in-serviced on 4/26/23 as to the new procedures for ensuring all licensed personnel certifications are kept current by the administrator. Once all credentials are entered into the payroll system, it will send an email alert to the employee and supervisor 30 days from licensure renewal for that employee. 4. The administrator will monitor weekly times eight weeks beginning 4/17/23 to ensure all newly hired employees requiring a license current credential data is entered into the payroll system and monthly for three months thereafter. The campus Executive Director will conduct observations of personnel files to ensure that all licensed employee's certifications are up to date monthly times three months. Results of audits will be reviewed at the quality assurance and performance improvement meetings starting 5/17/23 and monthly thereafter until a time in which consistent substantial compliance has been achieved as determined by the committee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/17/23

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F 880	Continued From page 8	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 9 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to change gloves during wound care while going from a dirty site to a clean site and failed to perform hand hygiene between glove changes for one (1) of four (4) residents observed during wound care. Resident #3 Findings include: Review of Facility Policy dated 10/2022 on "Clean Dressing Change" revealed, "Policy: It is the policy of this facility to provide wound care in a	F 880	1. Registered Nurse #2, who provided wound care for resident #3, was in-serviced on the importance of changing gloves and proper hand hygiene during wound care to decrease the potential for infection and/or cross contamination of the wound by the Assistant Director of Nursing. Resident #3 was assessed by the certified family nurse practitioner on 4/27/23 with no adverse infection from the event. 2. All residents with wounds have the potential to be affected.	

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F 880	Continued From page 10 manner to decrease the potential for infection and/or cross-contamination..... Policy Explanation and Compliance Guidelines:... 9. Loosen the tape and remove the existing dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wounds as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound....Pat dry with gauze.....14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered..." On 04/13/23 at 9:05 AM, observation of wound care to Resident # 3's abdomen performed by Registered Nurse (RN) #2 revealed this RN donned clean gloves, cleaned wound with wound cleanser, patted dry with 4x4s, applied Opticell AG, and covered with bordered dressing. RN#2 failed to perform hand hygiene and change gloves after cleaning the wound bed. RN #2 used the same gloves to clean the wound bed and to apply the Opticell AG and wound dressing. On 04/13/23 at 9:15 AM, an interview with RN#2 revealed that she realized that she had forgotten to wash her hands and change gloves after cleaning the wound. She confirmed that she knew she was supposed to wash her hands and change her gloves after cleaning the wound bed and before applying the wound treatment and dressing. RN#2 stated, "I paused a minute during the wound care when I remembered; but it was too late." RN#2 revealed that not changing gloves after cleaning the wound bed and before applying the wound treatment and dressing could cause germs to spread and it could contaminate the wound and cause an infection.	F 880	3. All licensed staff have been in-serviced on the importance of changing gloves and providing hand hygiene between glove changes during wound care to prevent the potential for infection and/or cross contamination of the wound by the Director of Nursing. This in-service education was completed on 4/24/23. 4. The Director of Nursing and/or the Assistant Director of Nursing services will conduct 3 observations of the wound care weekly times four weeks beginning 4/17/23 then monthly for 3 months to ensure staff providing wound care are following proper infection prevention protocols. Observation reports will be reviewed by the quality assurance and performance improvement plan committee starting on 5/17/23, and thereafter until a time in which consistant substantial compliance has been achieved and as determined by the committee.	

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F 880	Continued From page 11 On 04/13/23 at 10:00 AM, an interview with the Director of Nursing (DON) revealed it was in their policy to wash hands and change gloves between cleaning a wound and applying treatment and dressing to the wound bed. The DON revealed that not washing hands nor changing gloves could cause contamination and infection. On 04/13/23 at 10:10 AM, an interview with the Administrator revealed it was their policy to wash hands and change gloves during wound care. She confirmed that not washing hands and changing gloves after cleaning the wound bed and prior to applying the treatment and dressing to the wound could cause contamination. Record review of Resident #3's Admission Record documented admit date of 06/20/2019 with the following diagnoses to include: Essential Hypertension, unspecified, Morbid Obesity due to excess calories, Cerebral Palsy, unspecified, and Ventral Hernia without obstruction or gangrene. Record Review of Resident #3's Minimum Data Set Section C with Assessment Reference Date of 02/13/2023, documented his Brief Interview for Mental Status (BIMS) Score of 15 which indicated that Resident #3 was cognitively intact.	F 880		