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	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Health Center	2800 West Main Street Tupelo, MS 38801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on staff, and resident, caregiver, and responsible party interviews, record review, and facility policy review the facility failed to accurately complete an elopement assessment and identify risks to prevent an unsupervised resident from exiting the facility door for one (1) of three (3) residents reviewed for elopement and wandering. Resident #1. Findings Include: Review of the facility policy, Accidents and Interventions dated 05/05/19 revealed, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s) . An interview on 05/05/25 at 8:45 AM with Administrator (ADM), revealed that on 04/26/25, they had a resident to propel himself in his wheelchair outside the facility through an automated sliding door. She revealed that Resident #1 had been at the facility less than a week, he had limited mobility, and there had been no indications that he was an elopement risk. ADM revealed that on 04/26/25 at 7:20 PM, two resident assistants brought Resident #1 from the Assisted Living side, over to the 700 hall of the rehabilitation unit where he resided. She revealed that the resident assistants informed staff that Resident #1 was outside the automatic doors in his wheelchair. ADM revealed that they thought he belonged in the assisted living department and assisted him back into the building. ADM revealed that she arrived at the facility, reviewed the video surveillance, and determined that Resident #1 exited the front of the building through the automatic sliding glass doors and he was assisted back into the assisted living area of the building. An interview on 05/05/25 at 9:20 AM with ADM, revealed that Resident #1 had an elopement risk evaluation completed on admission and had a risk of zero for wandering and elopement documented. She revealed that when a resident's cognition was not good, they had to go by what the family said and the family had not told them that he had elopement risks. An observation and interview with the resident sitter on 05/05/25 at 9:40 AM, revealed Resident #1 sitting in his room in his manual wheelchair with his private caregiver sitting beside him. Resident #1 had a wander guard bracelet intact to his right arm. The caregiver revealed that was now sitting with Resident #1 during the day. She revealed that this behavior wasn't new for him, that at home, he would go outside during the night. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview on 05/05/25 at 10:25 AM with Resident #1's Responsible Party (RP), revealed that he had dementia, he was confused a lot, and he lived with her prior to coming to the facility. She revealed that Resident #1 fell on [DATE] at her house, broke his hip, had surgery and from the hospital, he admitted to the facility for therapy. She revealed that he had been there for four or five days when he got out of the facility. Resident #1's RP confirmed that he had wandered at home, he got out of the house at night, and they had to put alarms on all of the outside doors and they put cameras up. Resident #1's RP revealed that she signed his admission paperwork when he was admitted to the facility and she said the staff never asked her if he wandered or if he had ever gotten out of the house. Resident #1's RP confirmed that she didn't think he would go anywhere because he had a broken hip and was in a wheelchair and she never said anything to the facility. An interview on 05/05/25 at 11:10 AM with Registered Nurse (RN) #1, revealed that she completed all the admission assessments and evaluations during the admission process including the Elopement Evaluation. She revealed that if the resident was not able to give a good history or answer questions appropriately, she asked the family. RN #1 revealed that Resident #1 was confused, and she spoke with the RP about his history of wandering. RN #1 revealed that the RP didn't verbalize any issues or concerns with Resident #1 at that time, and that she usually asked in a more casual way about their behaviors at home and confirmed that she did not directly ask the question that was on the Elopement Assessment Form, Does the Resident have a history of elopement or an attempted elopement while at home? She revealed that she tried to make the admission process more personable with the family and she asked general questions. RN #1 revealed that during Resident #1's Elopement Risk Assessment, there was nothing said that would indicate that the resident had a history of wandering or elopement. RN #1 revealed that she would make sure and clarify from now on, so the question would be answered properly to ensure the safety of the residents. A phone interview on 05/05/25 at 4:12 PM, a phone with Registered Nurse Clinical Coordinator (RNCC), revealed that she received a phone call from the hall nurse on 04/26/25 that Resident #1 had gotten out of the facility unsupervised. She revealed that she came to the facility and checked him out. She revealed that he was very confused but was not hurt. She revealed that she called Resident #1's daughter, and she told her that he had been obsessed with locked doors at home prior to coming there and RNCC revealed that she did not verbalize that he had these wandering behaviors before. Record review of Resident #1's Admission Elopement Evaluation dated 04/21/25 revealed the question, Does the Resident have a history of elopement or an attempted elopement while at home and the answer No was marked. Record review of Resident #1's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Displaced Intertrochanteric Fracture of Right Femur and Dementia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/28/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 06 which indicated that he had severe cognitive deficits.