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	10/22/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

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	10/22/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review and interviews, the facility failed to ensure a resident's right to be free from neglect for one (1) of four (4) sampled residents, Resident #1.On 10/14/25 at approximately 10:16 AM, after returning to the facility from an appointment the facility abandoned Resident #1 on the facility's transport van. Resident #1 was left alone and unattended on the facility transport van for approximately two hours. At 12:15 PM, the facility staff located Resident #1 still strapped in the facility transport van. This resulted in Resident #1 missing her hydration, care and expressing a fear that she was anxious, and thought she would die.The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) at Past Non-Compliance (PNC). The SA determined the IJ began on 10/14/25 when the facility abandoned Resident #1 on the facility transport van and was removed on 10/15/25 when the facility put measures in place to protect all residents from further abuse and neglect. The facility's neglect to provide ordered care and services placed Resident #1 and other residents who use the facility transport van for transfers in a situation that could likely lead to serious injury, harm, impairment or death.The IJ and SQC existed at: 42 CFR 483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation - F600, Scope and Severity J PNC. The SA notified the facility's Administrator of the IJ and SQC at PNC on 10/22/25 and provided the Administrator with the IJ template.Based on the facility's implementation of corrective actions on 10/14/25, the SA determined the IJ and SQC to be PNC and the IJ was removed on 10/15/25, prior to the SA entrance into the facility on [DATE].Findings include:Record review of facility policy titled, Abuse, Neglect, and Exploitation dated 3/15/24, revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.During an interview with Resident #1's representative on 10/21/25 at 12:40 PM, it was revealed that the resident was transported to and from an appointment by the facility's Transportation Aide (TA). Resident #1 left the facility around 7:45 AM and around 10:00 AM she was secured in the bus to be taken back to the facility. The resident's representative went to the facility to have lunch with the resident, and the facility staff could not locate her. The TA was notified, and she reported that she had brought the resident back earlier that morning then she realized that she had been left on the bus. When the resident returned to the room, she was soaking wet, hot, thirsty, face was puffy and was extremely weak and tired. She revealed that the resident told her she was scared and thought she was going to have to spend the night on the bus and was even concerned that she would not survive the incident. The representative acknowledged that this incident caused the resident emotional distress, and she was now afraid to be transported in the facility's bus. An interview with Resident #1 on 10/20/25 at 1:30 PM, revealed she was left alone on the bus after a doctor's appointment. When they arrived at the facility, the driver got out of the bus and went into the building. The resident was hoping someone would come back to get her, but it was a long time before they returned. Resident #1 stated, I had no water and no phone, and I just sat there in that heat . The sun was shining and beating down, and I was hot and so thirsty for water and air. She stated she kept praying, Lord, it's just my time to die. I don't see no way out and nobody knows I'm here. I can't walk and I don't have a phone to call for help. She stated that being in the bus for so long made me sick and upset and I had to settle myself down and nothing like that had ever happened in my life. During the interview, the resident was in her wheelchair in her room and was pleasant and could articulate with her account of the event that occurred. During a phone interview on 10/21/25 at 4:07 PM, the Transportation Aide (TA) revealed she took Resident #1 to the hospital for a test and returned to pick her up to take her back to the facility around 10:00 AM. She returned to the facility, parked the bus, got out, and went inside the building. Around lunch time, Certified Nursing Assistant (CNA) #1 called her to ask about Resident #1 and she informed her that she had brought her back earlier that morning. She then realized that she did not remember returning the resident to her room, so she went to the bus and found the resident positioned where she had been secured. The resident was alert and said she was hot, but okay and was glad she came to assist her off the bus. She and CNA #1 got the resident out of the bus and back to her room. She acknowledged she had a lot on her mind, and she failed to ensure the resident was cared for appropriately and taken off the bus and returned safely to her room inside the facility. She stated she had