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	08/08/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, staff and resident interview, record review and facility policy review, the facility failed to ensure a resident's wheelchair was in good repair for one (1) of 26 residents reviewed during survey. Resident #236 Findings Include: Review of facility policy titled, Safe and Homelike Environment date implemented 1/2024, revealed under the Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible. This includes ensuring the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . An interview and observation on 08/05/24 at 2:20 PM, with Resident #236 revealed she was complaining of her wheelchair arm on the right side being messed up and bothering her. She stated that she had told the nurse twice, but no one has done anything. This observation revealed that the leather covering for the resident's right wheelchair arm rest was missing about three (3) to four (4) inches back from the front, exposing foam and metal that was rough to the touch in places. An observation and interview on 08/05/24 at 2:32 PM, with Certified Nurse Assistant (CNA) #1 confirmed that Resident #236's right wheelchair arm was torn. She stated she had not heard the resident complain. She stated that they could notify maintenance. The State Agency (SA) observed CNA #1 place a call to maintenance and reported Resident #236 needed a new wheelchair immediately. An interview on 08/06/24 at 10:09 AM with the Director of Therapy confirmed that Resident #236's right wheelchair arm torn, exposing foam and the metal was rough to the touch in places. She stated that the therapist had told her that the resident refused to have her wheelchair replaced, but wanted the arm fixed, but had failed to document any of that information. She admitted that the therapist should have documented something about the condition of the wheelchair. She stated that the therapist needed to make sure they are documenting issues like this because we want to be sure and provide the elders with all that they need. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Occupational Therapy (OT) on 08/06/24 at 11:41 AM, confirmed that she noticed when she picked the resident up for therapy on 6/6/24 that her personal wheelchairs overall condition was not good but does not recall specifically noticing the condition of the right arm rest. She revealed she talked with the resident about getting a new wheelchair, but the resident declined. She admits that she never documented anything and confirmed that today the resident complained of her right wheelchair arm and noticed the armrest was in bad condition. An interview on 8/7/24 at 9:45 AM with the Administrator confirmed that the Resident #236's wheelchair arm should have been repaired. She revealed that her expectation was that staff would document that the resident and family had been spoken with about getting a new chair, plus we have plenty of wheelchairs here, it could have been replaced. Record review of Resident #236's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Muscle Weakness.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41878 Based on staff interview, record review, and facility policy review, the facility failed to accurately submit information into the Minimum Data Set (MDS) assessment system for one (1) of 26 residents sampled. Resident #34 Findings include: Record review of facility policy titled, Conducting an Accurate Resident Assessment, dated October 2023, revealed, .The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) . Record review of Center for Medicare and Medicaid Services (CMS)'s Resident Assessment Instrument (RAI) dated October 2023 revealed, Insulin is a medication used to treat diabetes mellitus (DM). Steps for Assessment: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician . changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed Record review of Resident #34's Order Review History Report for May 2024 revealed no order for Insulin. Review revealed an order for Ozempic dated 9/29/23 to be given every seven (7) days. Record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/31/24, Section N - Medications, revealed one (1) insulin injection was received during the last seven (7) days or since admission/entry or reentry if less than 7 days. During an interview on 8/7/24 at 9:55 AM, the Registered Nurse MDS Coordinator revealed that due to her misunderstanding, she entered Ozempic as an insulin and since it is not an insulin, it should not have been coded as one. She stated this was an error on her part and this led to inaccurate information being submitted into the MDS system. She confirmed she entered that Resident #34 was receiving insulin when she was not, therefore, the MDS was submitted inaccurately. During an interview on 8/7/24 at 10:05 AM, the Administrator confirmed that Ozempic was not an insulin and it should not have been coded as an insulin on the MDS assessment. She confirmed the MDS assessment represents each resident's status at the time of the assessment and the facility failed to accurately complete the MDS assessment for this resident. Record review of Resident #34's Admission Record revealed the facility admitted the resident initially on 10/16/17. Resident #34 has current diagnoses that included Type 2 diabetes mellitus and Dementia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of MDS with Assessment Reference Date (ARD) of 5/31/24 revealed a Brief Interview for Mental Status (BIMS) of 5 indicating the resident has severe cognitive impairment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident that required the use of Enhanced Barrier Precautions (EBP) (Resident #85) and assistance with Activities of Daily Living (ADL's) (Resident #106) for two (2) of twenty-six care plans reviewed. Resident #85 and #106 Findings Include: Record review of the facility policy titled Comprehensive Care Plans dated 10/2022 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #85 Record review of Resident #85's Care Plan revealed Focus: The resident requires tube feeding r/t (related to) Dysphagia .Interventions .Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG (Percutaneous Endoscopic Gastrostomy) tube and Foley catheter . During an observation on 08/06/24 at 11:00 AM, of Resident #85's PEG tube care revealed an Enhanced Barrier Precaution sign on the inside of his door. Licensed Practical Nurse (LPN) #1 entered Resident #85's room, washed her hands, applied gloves and failed to apply a protective gown. During an interview on 08/06/24 at 11:20 AM, Licensed Practical Nurse (LPN) #1 revealed that she should have put on a gown before she provided Resident #85's PEG tube care to help prevent the spread of germs. She revealed that Enhanced Barrier Precautions were put in place to protect the nurse and to protect the resident from the spread of infection and she stated, I knew to do it, I was just nervous. LPN #1 revealed that residents with foley catheters, PEG tubes or open wounds were placed on enhanced barrier precautions. During an interview on 08/07/24 at 9:45 AM, Registered Nurse (RN) Infection Preventionist, revealed that LPN #1 should have worn gloves and a gown while providing PEG tube care as part of the enhanced barrier precautions. She revealed that residents with open wounds and those with indwelling devices such as PEG tubes were placed on Enhanced Barrier Precautions to protect the resident and the staff member to help prevent the spread of germs and possible infection. During an interview on 08/07/24 at 1:30 PM, RN Minimum Data Set (MDS) Coordinator, revealed that the purpose of the comprehensive care plan was to outline each resident's plan of care and what individualized care was needed and provided. She agreed that LPN #1 failed to follow the care plan when she did not wear a gown while she provided Resident #85's PEG Tube care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #85's Order Summary Report revealed an order dated 04/01/24, Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG tube and Foley catheter. Record review of Resident #85's Admission Record revealed an admitted [DATE] and had diagnoses that included Dysphagia and Encounter for Attention to Gastrostomy. Resident #106 Record review of the Care Plan with a date initiated of 12/23/22, for Resident #106 revealed Focus: Resident needs assist with ADL's (activities of daily living) . Interventions: Assist with adl's as needed . During an observation of Resident #106 on 8/5/2024 at 12:09 PM revealed, he was lying in bed, alert with confusion. The resident was unkempt, with his hair unbrushed and greasy on the edges. Gray facial hair observed on his face and above his lip, measuring approximately one fourth (1/4) inch in length. Long fingernails observed on both hands measuring approximately three-eights (3/8) inch in length. During an observation and interview with Licensed Practical Nurse (LPN) # 2 on 8/6/2024 at 10:35 AM, confirmed Resident #106 was unkempt, had long nails and needed to be shaved. During an interview with the Minimum Data Set (MDS) Coordinator on 8/7/2024 at 1:40 PM, revealed the purpose of the care plan was to provide an outline for resident care. She confirmed the activity of daily living (ADL) care plan was not followed for Resident #106. Review of the Admission Record revealed the facility admitted Resident #106 on 12/23/2022 with medical diagnoses that included Unspecified dementia. 47874

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for a resident dependent on staff for bathing, shaving, and nail care for one (1) of 26 residents sampled. Resident #106 Findings Include: Record review of the facility policy titled Activities of Daily Living dated 10/2023 revealed Policy . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . An observation of Resident #106 on 8/5/2024 at 12:09 PM revealed, he was lying in bed, alert with confusion. The resident was unkept, with his hair unbrushed and greasy on the edges. Gray facial hair was observed on his face and above his lip, measuring approximately one fourth (1/4) inch in length. Long fingernails were observed on both hands measuring approximately three-eights (3/8) inch in length. An observation and interview with Certified Nurse Aide (CNA) # 2 on 8/6/2024 at 10:25 AM revealed, Resident # 106 was scheduled to get his shower on Monday, Wednesday, and Friday on the 3-11 shift. She explained that the resident should have gotten a shower last night and stated, He does not look like he was showered. CNA #2 revealed the aides were responsible for shaving the male residents with showers and cutting their nails if the resident was not a diabetic. She confirmed Resident #106 needed shaving, and his nails needed to be cut. CNA #2 revealed the resident could scratch himself and cause injury. An observation and interview with Licensed Practical Nurse (LPN) # 2 on 8/6/2024 at 10:35 AM, confirmed Resident #106 was unkempt, had long nails and needed to be shaved. She revealed the resident was not a diabetic, so the aides were responsible for cutting his nails when needed. Record review of the Kardex for Resident #106 revealed .Bathing: ADL -Bathing as ordered . An interview with the Director of Nursing (DON) on 8/7/2024 at 1:35 PM, revealed with Resident #106's ADL care, her expectations were for the aides to include nail care (cleaning, cutting, and filing) and shaving on designated shower day. Review of the Admission Record revealed the facility admitted Resident #106 on 12/23/2022 with medical diagnoses that included Unspecified dementia

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than five (5) % (percent) for two (2) of 28 medication opportunities involving Resident #84. Medication error rate was 7.14%. Findings Include: Review of the facility policy titled Medication Administration dated 1/2024 revealed Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines: 10. Ensure that the six rights of medication administration are followed .c. Right dosage . An observation of medication pass, with Licensed Practical Nurse (LPN) #3 on 8/7/2024 at 8:09 AM, revealed she prepared and administered MiraLax 17 grams one capful mixed in water to Resident #84. She then handed the resident a bottle of Flonase (Fluticasone Propionate) nasal spray, in which he administered one spray to each nostril. Record review of Resident #84's August 2024 Medication Administration Record (MAR) revealed an order dated 11/1/2022, Fluticasone Propionate Suspension (Allergies) 50 MCG (micrograms)/ACT (actuation) 2 (two) spray in each nostril one time a day related to Allergic Rhinitis. Also revealed an order dated 4/29/2024, MiraLax Oral Powder (stool softener) 17 GM (grams)/scoop give 34 gram orally two times a day for constipation in 240 ml (milliliters) of liquid. An interview on 8/7/2024 at 8:16 AM with LPN #3, confirmed she did not administer Resident #84's MiraLax and Flonase according to the physician order. She stated the resident liked to give his own nasal spray, but she should have instructed him to give the two sprays instead of one. She explained that she overlooked that the resident was supposed to have 34 grams of MiraLax, and she should have given two capfuls. LPN #3 stated, I just missed it. She revealed not getting the entire dosage of MiraLax could cause constipation. An interview on 8/7/2024 at 10:10 AM, with the Director of Nursing (DON), confirmed Resident #84's physician orders were not followed. She revealed her expectations were for the nurses to view the Medication Administration Record (MAR) and ensure they were giving the correct ordered dose before administration. Record review of the Admission Record revealed the facility admitted Resident #84 on 12/20/2023 with medical diagnoses that included Allergic Rhinitis and Constipation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interviews, record review, and facility policy review the facility failed to prevent the possibility of the spread of infection as evidenced by failing to ensure Enhanced Barrier Precautions were followed during a resident care treatment for one (1) of four (4) resident care treatments observed. Resident #85. Findings Included: Record review of the facility policy Gastrostomy Site Care dated 05/2023 revealed Policy: It is the policy of the facility to perform gastrostomy site care as ordered and per current standard of practice. Policy Explanation and Compliance Guidelines .10. Apply any other PPE (Personal Protective Equipment) as needed to protect self from any exposure to infectious material and to comply with any isolation precautions ordered . Record review of the undated facility policy titled, Enhanced Barrier Precautions revealed .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities 4. High-contact resident care activities include .g. Device care or use: . urinary catheters, feeding tubes An observation on 08/06/24 at 11:00 AM, of Resident #85's Percutaneous Endoscopic Gastrostomy (PEG) tube care revealed an Enhanced Barrier Precaution sign on the inside of the door. Licensed Practical Nurse (LPN) #1 entered Resident #85's room, washed her hands, applied gloves and failed to apply a protective gown prior to beginning care. An interview on 08/06/24 at 11:20 AM with LPN #1 revealed that she should have put on a gown before providing Resident #85's PEG tube care to help prevent the spread of germs. She revealed that enhanced barrier precautions were put in place to protect the nurse and to protect the resident from the spread of infection and she stated, I knew to do it, I was just nervous. LPN #1 revealed that they followed enhanced barrier precautions when providing care to anyone with a foley catheter, PEG tube, or open wounds. An interview on 08/07/24 at 9:45 AM with Registered Nurse, Infection Preventionist revealed that LPN #1 should have worn gloves and a gown while providing PEG tube care as part of the enhanced barrier precautions. She revealed residents with open wounds and those with indwelling devices such as PEG tubes were placed on enhanced barrier precautions to protect the resident and the staff member and to help prevent the possible spread of infection. RN Infection Preventionist revealed that bacteria could be passed from the resident to staff on their uniforms and infection could be transmitted to other residents without protective gowns in use. An interview on 08/07/24 at 9:55 AM, with the Director of Nursing (DON), revealed residents with open wounds, foley catheters and PEG tubes were placed on enhanced barrier precautions to prevent the spread of infection. She agreed that LPN #1 should have worn a gown and gloves when providing PEG tube care for Resident #85 to prevent the spread of potential infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #85's Order Summary Report revealed an order dated 04/01/24, Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG tube and Foley catheter. Record review of Resident #85's Admission Record revealed an admitted [DATE] and had diagnoses that included Dysphagia and Encounter for Attention to Gastrostomy.