MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18BA	A. BUILDING: _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD ALZHEIMER'S CARE CENTER	298 CAHAL STREET HATTIESBURG, MS 39401

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M 000	Initial Comments The State Agency (SA) conducted four (4) Complaint Investigations (CI MS #23651, CI MS #23698, CI MS #23700, and CI MS #23710, at the facility from 12/27/23 through 12/28/23. CI MS #23651 and CI MS #23710 were two facility reported incidents related to resident to resident abuse. CI MS #23698 and CI MS #23700 were anonymously reported complaints related to the same resident to resident abuse and neglect. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and M500 was cited related to the four (4) Complaint Investigations.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		1/24/24

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately	M 500		

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M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III	M 500	" Resident #1 was assessed after the incident on 12/9/23 by the Nurse	

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M 500	Continued From page 4 Based on observation, interviews, record review, and facility policy review, the facility failed to protect residents' rights to be free from resident to resident physical abuse for four (4) of seven (7) sampled residents. Resident #1, Resident #2, Resident #3, and Resident #4. Resident #1 was initiated physical altercations on 12/9/23 and 12/19/23 which resulted in: a. Resident #1 receiving bruising and a skin tear. b. Resident #2 receiving bruising and skin discoloration under the right eye. c. Resident #3 receiving redness to her cheek. d. Resident #4 receiving bruising, skin tears, and a hematoma. Findings include: A review of the facility's policy "Abuse Prevention Program", undated, revealed "Our residents have the right to be free from abuse, neglect ... This includes but is not limited to ...physical abuse ... As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to ... other residents ... " Resident #2 Record review of the facility's investigation, dated 12/9/23 at 3:02 PM, revealed, "Nursing Description: Observed resident (Resident #1) standing in another resident's room near doorway with face, shirt, and glasses wet ...Injuries Observed at Time of Incident ... (Resident #1) Bruise Right Forearm, Bruise Left Forearm, Skin Tear Left Elbow ...Notes 12/17/2023 Resident #1 wandered into another resident room and... (Resident #2) was trying to force him out and began pulling on Resident #1 before she hit this resident and threw water on him.	M 500	Practitioner for injuries and received orders for medication adjustments. Resident #1 was placed under increased observation by staff. Resident #1 was transferred to Behavioral Health Unit on 12/21/23 for evaluation and treatment of aggressive behaviors. Resident #1 was discharged from facility on 12/22/23. Resident #2 was assessed by the Registered Nurse Supervisor on 12/9/23 for injuries and treated accordingly. Resident #3 was assessed by the Registered Nurse Supervisor on 12/9/23 for injuries and treated accordingly. Resident #1 and Resident #4 were assessed by the Registered Nurse Supervisor on 12/19/23 for injuries and treated accordingly. " All Residents have the potential to be affected by the deficient practice. " All staff were in-serviced on Abuse and Neglect, by the Staff Development Nurse, beginning 1/3/24 and completed by 1/18/24. The Psychiatric Nurse Practitioner will conduct training for all staff on 1/17/24 on Common Dementia Related Behaviors and Redirection. Shift Huddles will be initiated 1/11/24 which will include discussion of individualized interventions for residents with behaviors. Care Plans will be updated with target behaviors to include individualized interventions for behaviors that are discussed during the Huddles. Care Plans of the Residents with reoccurring behaviors that affect other residents, will be audited and updated to include individualized interventions for behaviors. This will be completed by 1/23/24. " Behavior documentation and nurses	

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M 500	Continued From page 5 Record review of the "Progress Notes", revealed a "Nurses Note", for Resident #1, dated 12/9/23 at 3:19 PM, " Resident #2 stated get out. Observed resident (Resident #1) standing in another resident's room hold his pants with wet shirt, face and glasses. Other resident (Resident #2) yelling at resident ..." Record review of the "Progress Notes", revealed a "Nurses Note", for Resident #2, dated 12/9/23 at 3:55 PM, " ...Observed resident #2 walking down the hallway towards her room, but then heard Resident #2 "yelling get out" and was pointing her finger towards Resident #1 stating again, "Get out of here" Resident #2 was bleeding from right middle finger and chin area ...Resident #2 stated, "I was trying to get that man out of a room because he has no business in her room" ...Resident #2 stated she did not know what happened to Resident #2's face and hand. Asked if she was hit by other resident or did she hit him. Resident #2stated, "I might have hit him I can't remember, and he might hit me, I don't know ..." Record review of the "Progress Notes", revealed a "Nurses Note", for Resident #2, with an "Effective Date" of 12/10/23 at 6:17 AM, " ...Resident noted with bruising under right eye, just above right temple, a bandaid across right side of chin. When asked what happened resident stated it was Resident #1 "the new man". Resident #2 stated she had follow Resident #1 into another female's room to get him to come out. Resident #2 stated they argued, then it came to blows. Resident #1 hit her and she hit him. At 8:15 PM on 12/27/23, during an observation and interview with Resident #2, she was sitting alone at a table. Observed red purple bruising	M 500	note documentation in the Residents Medical Record will be reviewed 5 x week x 12 weeks by the Administrator and Director of Nursing beginning 1/4/23 to ensure effectiveness of behavior interventions. Shift Huddle Documentation will be audited 5 x week x 12 weeks by the Director of Nursing beginning 1/4/24 to ensure behaviors and interventions are being discussed and addressed. Audits will be reviewed by the Quality Assessment and Assurance Committee x 3 months beginning on 1/24/24 to ensure sustained compliance.	

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discoloration under right eye and to cheek bone. Resident explained she was not exactly sure what happened between her and Resident #1 but when he popped her, she popped him back. She doesn't remember him coming into her room, but stated it would not surprise her that he did, because he walked around and went into everyone's rooms.

A record review of the "Admission Record" revealed the facility admitted Resident #2 on 01/31/17 with a diagnoses that included Alzheimer's Disease.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/23 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

Resident #3

A record review of the facility's investigation, dated 12/9/23 at 9:10 PM, revealed, " (Resident #1) was down at the end of the hallway exit seeking and trying to go into other residents rooms was trying to shove his way into a room and when other resident was trying to push door closed, Resident #1 turned around and hit Resident #3 in the face, on the left side ..."

A record review of the "Progress Notes" revealed a "Nurses Note", dated 12/9/23 at 10:40 PM for Resident #3, that read, Resident #3 was in her room, when Resident #1 came into her room. Resident #3 was trying to tell Resident #1 to get out of her room, she tried to close the door when Resident #1 swung and hit her in the face. Review of the Progress Note revealed Resident #3 was assessed and found redness to the left

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cheek, but resident denied pain.

A record review of Resident #1's "Progress Notes" dated 12/09/23 10:46 PM revealed was verbally aggressive with staff and at times combative. Resident was attempting to enter the room of another resident (Resident #3) when he opened door other resident reached for door and yelled "get out of my room" and began to try to close the door, as Resident #3 was trying to push the door closed, Resident #1 turned around and hit Resident #3 in the face, on the left side on the cheek area.

A record review of the "Admission Record" revealed the facility admitted Resident #3 on 10/06/22 with a diagnosis of Alzheimer's Disease.

A record review of the Quarterly MDS, with an ARD of 11/08/23, revealed Resident #3 had a BIMS score of 10, which indicated her cognition was moderately impaired.

On 12/27/23 at 7:45 PM, during an interview with Licensed Practical Nurse (LPN) #2, she explained Resident #1 was admitted with Alzheimer's and Dementia and was having a hard time adjusting to the new atmosphere. She stated she was working on the evening shift when Resident #1 had a physical altercation with Resident #3. She was on the phone with the Registered Nurse (RN) supervisor due to Resident #1 had been exhibiting physical aggression toward staff. Resident #1 was attempting to go into Resident #3's room, and a CNA was trying to redirect him. While the CNAs were getting Resident #1 out of the room, Resident #1 turned and hit Resident #3 on the side of the face. Resident #3 did have some redness only to her left cheek but nothing else. Resident #1 was placed on one-on-one

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M 500	Continued From page 8 (1:1) observation. At 8:10 PM on 12/27/23, during an observation and interview with Resident #3, she explained she doesn't remember the man or that he hit her. There were no bruises or discolorations observed on the resident's face. Resident #4 A record review of the facility's investigation, dated 12/19/23 at 9:45 PM, revealed, "Resident went into room across the hall ...found (Initials of Resident #1) on top of another resident (Resident #4) pulling his hair with his left hand and punching him in the neck with his right hand ..." Record review of the "Progress Notes" revealed a "Skin Only Evaluation", dated 12/19/23 at 10:24 PM, revealed Resident #4 had a skin tear and bruising to the right forearm, bruising to the left forearm and elbow, a scratch to the upper back, redness to his head, and his right forearm had a hematoma. Skin note revealed, " ...Hematoma noted to right forearm. Knot noted next to area. A record review of Resident #1's "Progress Notes" dated 12/19/23 at 10:27 PM revealed "... writer found resident on top of another resident (Resident #4) pulling his hair with his left hand and punching him in the neck with his right hand ... at 10:45 PM resident was found in another resident room when tried to remove he punched the aide in the jaw ..." On 12/27/23 at 8:05 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained she was working on the night Resident #1 had an altercation with Resident #4. She heard a nurse yelling for help, so herself and another CNA went	M 500		

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down the hall and found Resident #1 in Resident #4's room. Both residents were locked together with Resident #1 on top of Resident #4, and Resident #1 was punching Resident #4. The staff separated them and Resident #1 hit staff members during the separation.

A record review of the "Admission Record" revealed the facility admitted Resident #4 on 02/21/23 with a diagnoses that included Alzheimer's Disease.

A record review of the "Quarterly MDS" with an ARD of 11/15/23 revealed Resident #4 had a BIMS score of 06, which indicated he had severe cognitive impairment.

Resident #1

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 11/28/23 with diagnoses of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.

A record review of the MDS, with an ARD of 12/4/23, revealed Resident #1 had a BIMS score of 01, which indicated he had severe cognitive impairment. Further review of record revealed he had Physical and Verbal behavioral symptoms directed towards others, his behavior impacted others, and exhibited Wandering behaviors that intruded on the privacy of others.

At 7:30 PM on 12/27/23, during an interview with Licensed Practical Nurse (LPN)#1, she explained Resident #1 was sent out to Behavioral Unit on 12/21/23 and was no longer in the facility. She explained she never saw any physical incidents

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with Resident #1 with other residents, but he would go in and out of other resident's rooms cursing the other residents, which caused the residents to become uncomfortable. He would get aggressive towards staff and he was admitted to the facility because his wife could no longer handle him at home.

At 10:45 AM on 12/28/23, during an interview with the Social Services Director (SSD), she explained she was aware that Resident #1 had some behaviors and she offered suggestions to the staff on how to manage those behaviors. The SSD did not have staff to sign an in-service related to her suggestions, she would pull them over to the side and talk to them. The SSD stated that the facility reviewed documentation in the morning meetings and interventions were discussed for Resident #1, including placing signs on the doors of the rooms Resident #1 would try to enter. However, the signs were not an effective intervention and Resident #1 continued to try to enter other resident's rooms. Resident #1 was referred to Mental Behavioral Health services, but he would not participate in the services. The SSD stated that many interventions were attempted, but most were not effective because Resident #1 was difficult to redirect.

At 11:30 AM on 12/28/23, during an interview with the Director of Nursing (DON), she explained that Resident #1 had not been taking his medication at home and that he was placed in the facility so the staff could ensure he took his medications and manage his dementia because his wife was unable to get him to take his medications. She stated that although the staff would often provide 1:1 supervision, it was not a documented intervention until after the incident

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with Resident #4 on 12/19/23. She said that she expected 1:1 supervision to mean that the staff would get between Resident #1 and the residents' room doors and intervene before Resident #1 got into the rooms. She explained that the Psychiatric Nurse Practitioner (NP) visits the facility two times a month, but the facility's general NP visits the facility more often and had ordered medication changes for Resident #1. After the incident with Resident #4, the facility decided that Resident #1 would benefit from an inpatient behavioral health stay, and he was placed on 1:1 observation until he was able to be transferred.

At 12:45 PM on 12/28/23, during an interview with the Administrator, he confirmed the facility was aware that Resident #1 would require an adjustment period after admission. He explained that he had provided education to the staff regarding how to successfully conduct 1:1 supervision and observation for Resident #1. He stated he would stay after hours with the staff on the Unit to demonstrate how to engage the resident and how to walk with him, keeping him out of other resident's rooms. He said that most of the time, Resident #1 would go to doors and just rattle the door handles. Sometimes he would go into other resident rooms and immediately turn around and walk out, and sometimes he would stay in the room longer. He explained that some staff were better at managing his behaviors than others. He had provided instructions on how to approach Resident #1 and if his behaviors were not bothering anyone, to "let him be". The Administrator admitted there was no official in-service sign in sheet or documentation of the training that he provided that would indicate which staff received the training. After the incident between Resident #1 and Resident #4, extra staff

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD ALZHEIMER'S CARE CENTER	298 CAHAL STREET HATTIESBURG, MS 39401

(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) COMPLETE DATE
M 500	Continued From page 12 were put on the schedule for 1:1 supervision until the resident could be transferred to a behavioral facility. The facility tried to let Resident #1 adjust to the new situation of being in a facility and had attempted medication changes to manage his behaviors.	M 500		