STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A416	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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F 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 related to the same resident to resident abuse and neglect. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600 and F655 related to the four (4) complaint investigations. The facility held a license for 60 beds, with a census of 58.	F 000		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		1/24/24

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

Electronically Signed | 01/11/2024

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F 600	Continued From page 1 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	F 600	" Resident #1 was assessed after the incident on 12/9/23 by the Nurse 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	

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F 600	Continued From page 2 resident and threw water on him. 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	F 600	individualized interventions for behaviors. This will be completed by 1/23/24. " Behavior documentation and nurses 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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and interview with Resident #2, she was sitting alone at a table. Observed red purple bruising 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

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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 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

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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 (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 ..."

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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 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.

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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 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

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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 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

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F 600	Continued From page 9 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 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.	F 600		
F 655 SS=H	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		1/24/24

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F 655	Continued From page 10 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to develop a baseline care plan within 48 hours that addressed safety concerns, identified the resident's need for supervision, or included behavioral interventions for a resident with behavioral aggression, for one (1) of seven (7) sampled residents. Resident #1. Resident #1 was involved in a physical altercations on 12/9/23 and 12/19/23 which resulted in: a. Resident #2 receiving bruising and skin discoloration under the right eye and bleeding to the right middle finger and chin area. b. Resident #3 receiving redness to her cheek. c. Resident #4 receiving bruising, skin tears, and a hematoma.	F 655	" Resident #1 was transferred to Behavioral Health Unit on 12/21/23 and discharged from facility on 12/22/23. " All Residents have the potential to be affected by the deficient practice. " All current Residents have a Comprehensive Care Plan completed so no Baseline Care Plans required updating. The User Defined Assessment used as the Baseline Care Plan was updated on 1/11/24 to include a section for Behavior Interventions. All staff responsible for completing the Baseline Care Plan will be trained on the new User Defined Assessment by the Director of Nursing on 1/18/24. All Nursing staff will be trained	

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F 655	Continued From page 11 Findings include: A record review of the facility's policy "Baseline Care Plan", revised 11/06/23 revealed " ... The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines ... 2 ... b. Interventions shall be initiated that address the resident's current needs including i. Any health and safety concerns to prevent decline or injury ... ii. Any identified needs for supervision, behavioral interventions ..." 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 "Baseline Careplan and Summary" for Resident #1 revealed "Admission: 11/2/2023". Review of Section 4. Dietary, Therapy and Social Services revealed "... Section C. Social Services ... 3. Behavioral Concerns Resident has potential to be verbally and physically aggressive ... Signed by Social Services on 12/08/23 ..." The Baseline Care Plan did not include any interventions to address health and safety concerns to prevent injury and did not identify needs for supervision or behavioral interventions for Resident #1. At 3:30 PM on 12/28/23, during an interview with Licensed Practical Nurse (LPN) #1/Care Plan	F 655	by the Staff Development Nurse on the Baseline Care Plan to include behavior interventions by 1/18/24. " The Baseline Care Plans for new admissions will be audited 1 x week x 12 weeks by the Director of Nursing beginning 1/4/24 to ensure that the baseline care plan has been completed accurately and include interventions for residents with behaviors. Audits will be reviewed by the Quality Assessment and Assurance Committee x 3 months beginning on 1/24/24 to ensure sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A416	A. BUILDING _____ B. WING _____	C 12/28/2023

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F 655	Continued From page 12	F 655		

nurse, she explained the baseline care plans are completed within 48 hours and every department completed their own sections. The Social Services Director completed the Behavioral Section of the care plan and documents any interventions needed.

At 4:15 PM on 12/28/23, during an interview with the Social Services Director (SSD), she explained she completed the Social Services portion of Resident #1's Baseline Care Plan and confirmed the date completed was 12/08/23. The SSD stated that the Baseline Care Plan was based off the resident's history and life story and was a User Defined Assessment (UDA) in the computer software. She stated there was nowhere on the UDA to input interventions for resident behaviors, but there was an area to input concerns.

At 4:45 PM on 12/28/23, during an interview with the Administrator and the Director of Nursing (DON), they both explained they thought the Baseline Care Plan included everything, including interventions, to care for the resident and they were not aware that it did not include interventions that addressed the resident's current needs including any identified needs for supervision or behavioral interventions.

Resident #2
Record review of the Facility Investigation dated 12/9/23 at 3:02 PM, revealed Resident #1 was found standing in another resident's room near the doorway. Resident #2 attempted to remove Resident #1 from the other resident's room by pulling on him and threw water on his face, shirt and glasses causing Resident #1 to sustain bruising on his right and left forearm and a skin tear to his left elbow. Resident #2 had bleeding to

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F 655	Continued From page 13 the right middle finger and chin area. Resident #3 Record review of the Facility Investigation dated 12/9/23 at 9:10 PM, revealed Resident #1 was attempting entry into Resident #3's room while she was trying to prevent it by pushing on the door. Resident #1 turned around and hit Resident #3 in the face on the left side, receiving redness to her cheek. Resident #4 Record review of the Facility Investigation dated 12/19/23 at 9:45 PM, revealed Resident #1 was found in Resident #4's room, on top of Resident #4, punching him in the neck with his right hand and pulling his hair with his left hand. Resident #4 received a hematoma to the right forearm, a skin tear and bruising to the right and left forearm and elbow, a scratch to the upper back, and redness to his head.	F 655		