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

(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 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 of Operation for Alzheimer's Disease/Dementia Care Unit, state licensure requirements and M0011 was cited related to the four (4) Complaint Investigations.	M 000		
M 011	103.2 Care Plans Care Plans. Individual care plans shall be developed by the staff for each resident. This Statute is not met as evidenced by: Level III 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 physical altercations on 12/9/23 and 12/19/23 which resulted in Resident #2 receiving bruising and skin discoloration under the right eye, Resident #4 receiving bruising, skin tears, and a hematoma, and Resident #3 receiving redness to her cheek.	M 011	" 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 by the Staff Development Nurse on the	1/24/24

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M 011	Continued From page 1 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 03:30 PM on 12/28/23, during an interview with Licensed Practical Nurse (LPN) #1/Care Plan nurse, she explained the baseline care plans are completed within 48 hours and every department	M 011	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.	

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M 011	Continued From page 2	M 011		

completed their own sections. The Social Services Director completed the Behavioral Section of the care plan and documents any interventions needed.

At 04:15 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 04:45 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 the right middle finger and chin area.

Resident #3

MSDH - Health Facilities Licensure and Certification

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M 011	Continued From page 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. 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.	M 011		