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 _____	10/03/2019

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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 09/30/19 through 10/3/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation and cited deficiencies at F-623, F-641, and F-644. The facility was licensed for 60 beds, with a census of 60, at the time of survey.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		10/30/19

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

Electronically Signed | 11/01/2019

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.

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F 623	Continued From page 1 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 2 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the family, in writing, of the reason residents were sent to an acute hospital for two (2) of two (2) resident hospitalizations, Resident #47 and Resident #60. Findings Include:	F 623	Bedford Alzheimer's Care Center acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations please accept this Plan of Correction as our allegation of compliance. Bedford	

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F 623	Continued From page 3 The facility failed to provide a policy/protocol for written notice of transfer. During an interview on 10/03/19 at 09:41 AM, the Administrator stated the facility does not have a policy regarding notification of transfers. Resident #47 Review of Resident #47 Nurse's Notes, dated 6/17/2019, revealed Resident #47 was admitted to the hospital, and a bed hold notice was provided, however, there was no written notification to the resident representative of the reason for the transfer. During an interview on 10/02/19 at 03:08 PM, Licensed Practical Nurse (LPN) #2 stated Resident #47 was sent to the hospital, due to altered mental status on 6/17/2019. Resident #60 Record Review of the facility's Bed Hold Report revealed Resident #60 was admitted to the hospital on 3/26/2019, 3/29/19, 7/1/19, and 7/17/19. Bed hold letters and letters to the Ombudsmen were completed, however, the facility failed to notify the resident representative, in writing, the reason Resident #60 was sent to the hospital. During an interview on 10/02/19 at 04:27 PM, LPN #2 revealed Resident #60 had problems with swallowing and was sent to the hospital for evaluation and feeding tube placement. During an interview on 10/03/19 at 9:14 AM, the Director of Nursing (DON) confirmed the the family was not notified, in writing, of the reason the residents were sent to the hospital. The DON said her interpretation of the regulation was the	F 623	Alzheimer's Care Center, LLC response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. * Resident Representatives for Resident #47 and Resident #60 were mailed a second Transfer Notice Form on 10/29/2019. The Administrator placed these letters in the mail. This second Transfer Notice Form states the reason/symptoms exhibited by the residents which resulted in a transfer to a hospital. The Administrator educated the Business Office personnel and the Registered Nurses on the specificity required by the Transfer Notice Form on 10/23/19. Specific information related to the reason for transfer must be written on this Transfer Notice Form for all future resident transfers. * All residents have the potential to be affected by this alleged deficient practice. * Through Daily Continuous Quality Improvement meetings, residents out of the building (currently or since last meeting) will be announced. The Business Office Manager or Business Office Assistant will note these residents on the Transfer Notice Mailing Log and Transfer Notices will be mailed to the Resident Representative. * The Business Office Assistant will complete the mailing process and document the date and content of the Transfer notices that are mailed out. This Transfer Notice Mailing Log will be maintained and presented at the Quarterly	

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F 623	Continued From page 4 facility should notify the family in writing that the resident went to the hospital or left the facility; not the reason the resident went to the hospital.	F 623	Quality Assurance Review for recommendations or changes as needed. This plan of correction is integrated into the Quality Assurance system.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to accurately reflect the resident's status on the Minimum Data Set (MDS) for two (2) of 26 MDS(s) reviewed for accuracy, Resident #31 and Resident #51. Findings include: Review of the facility policy entitled, "Resident Assessment Instrument," dated March 2019, revealed that it is the policy of this facility that a comprehensive assessment of a resident's needs shall be made upon the resident's admission and periodically as mandated by the Omnibus Budget Reconciliation Act (OBRA) and Medicare guidelines. The facility policy noted that the Nursing department will be responsible for completing and entering section(s) A, G, GG, H, I, J, L, M, N, O, P, S, V, and Z of the Minimum Data Set (MDS) into the computer system. The facility policy noted that any flags for this MDS section will be reviewed and resolved prior to submission of the MDS, to ensure accuracy of the MDS. The facility policy also noted that all persons who have completed any portion of the MDS Resident Assessment Form MUST sign	F 641	* On 10/23/2019, the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/2019 was modified by the MDS nurse for Resident #31. The modified MDS now shows Alzheimer's Disease as an active diagnosis. Resident #51's MDS with an ARD of 9/3/19 was modified by the MDS nurse on 10/23/2019 to reflect that this resident did have a Level II Preadmission Screening and Resident Review completed. * All residents have the potential to be affected by this alleged deficient practice. * Level II information will be compiled by the Social Services Director beginning 10/28/19. This information is then presented at Weekly Quality Assurance review where the MDS Coordinator will confirm that the MDS instrument is completed accurately to reflect the presence of any Level II PASARR. On 10/28/19, both Social Services Director and MDS nurse received education from the Administrator as well as a phone call conversation with Ascend on 10/28/19 on	10/30/19

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F 641	Continued From page 5 such document attesting to the accuracy of such information. Resident #31 Review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/2019, revealed in Section I4200, Alzheimer's disease is not checked as an active diagnoses for Resident #31. However, Resident #31's medical records document, "Diagnosis Report," revealed Resident #31 had a diagnosis of Alzheimer's Disease listed as an admitting diagnosis, with an onset date of 10/19/2017. During an interview, on 10/2/2019 at 9:47 AM, the facility's Director of Nursing (DON) revealed that the MDS for Resident #31 was not coded correctly on the diagnoses section, because the resident does have a diagnosis of Alzheimer's Disease. During an interview, on 10/2/2019 at 9:51 AM, Licensed Practical Nurse (LPN) #1/ MDS Coordinator, confirmed that the MDS for Resident #31 was not coded for the diagnosis of Alzheimer's disease. LPN #1 stated that Resident #31 does have the diagnosis listed in her medical record. Resident #51 Review of Resident #51's Significant Change MDS, with an ARD of 9/3/2019, revealed that Section A1500 should have been coded as to indicate one (1) "Yes" for the Preadmission Screening and Resident Review (PASRR); and section A1510 should have been coded as to indicate that Resident #51 had a Serious Mental Illness, as evidenced by the active diagnoses marked in Sections I5800-Depression,	F 641	accuracy of assessments. * The Social Services Director and/or MDS Coordinator will present their findings in weekly Quality Assurance meetings and in Quarterly Quality Assurance review for further review, recommendations or changes as needed. This plan of correction is integrated into the Quality Assurance system.	

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F 641	Continued From page 6 I5950-Psychotic Disorder, and I6000-Schizophrenia. Review of Resident #51's medical records document, "Diagnosis Report," revealed Resident #51 had diagnoses of Delusional Disorders, Paranoid Schizophrenia, and Major Depressive Disorder listed as an admitting diagnosis with an onset date of 2/22/2016. Review of Resident #51's, "Mississippi PASRR Level II Change in Status Request," dated 1/4/2019, revealed that Resident #51 was previously evaluated through Pre-Admission Screening and Resident Review (PASRR) on 2/18/2016. The document revealed that a PASRR Level II change in status request was being made, due to an increase in behavioral, psychiatric, or mood-related symptoms. The document revealed in Section C that there is a known mental illness. The document revealed that Resident #51 had the following two (2) Major Mental Illnesses: Schizophrenia and Delusional Disorder. The document also revealed that the resident has the following mental disorder: Depression. During an interview, on 10/2/2019 at 9:47 AM, the DON confirmed the PASARR Level II for Resident #51 was completed on 2/22/2016, and the Resident #51 was approved for Long Term Care (LTC) with written notification from the state designated authority. During an interview, on 10/2/2019 at 9:51 AM, LPN #1/ MDS Coordinator, confirmed that the Significant Change MDS with an ARD of 9/3/2019, was coded incorrectly. She stated Resident #51 did have a Level II PASRR	F 641		

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F 641	Continued From page 7 completed and did have mental illness diagnoses. LPN #1 stated that she thought that Sections A1500 and A1510 only had to be addressed one time, and that the PASARR would only be coded one time, and that would be on the first comprehensive MDS.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review, the facility failed to refer residents to the appropriate state designated authority for Level II Preadmission Screening and Resident Review (PASARR) for two (2) of 24 sampled resident's reviewed for Preadmission Screening and Resident Review (PASARR), Resident #11 and Resident #27.	F 644	* On 10/28/2019 the Social Services Director referred Resident #11 and Resident #27 to the appropriate state designated authority for Preadmission Screening and Resident Review (PASARR) Level II. The referral was based upon the diagnoses of Bipolar Disorder and Alzheimer's/Dementia in	10/30/19

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F 644	Continued From page 8 Findings include: Review of the facility's "Admission Criteria" policy, revised March 2019, Resident #11 The facility admitted Resident #11 on 10/23/2013, with diagnoses to include Bipolar Disorder and non-Alzheimer's Dementia. The facility completed the Preadmission Screening and Resident Review (PASARR) on 10/18/2013. The facility failed to refer Resident #11 to the appropriate state designated authority for Preadmission Screening and Resident Review PASARR Level II, related to the Bipolar Disorder. Review of Resident #11's Annual Minimum Data Set Date (MDS), with the Assessment Reference Date (ARD) date of 7/23/2019, revealed Resident #11 was coded for a diagnosis of Bipolar Disorder. Resident #27 The facility admitted Resident #27 on 11/6/2017, with diagnoses to include Bipolar Disorder and Dementia. The facility completed the PASARR on 11/6/2017. The facility failed to refer Resident #27 to the appropriate state designated authority for Preadmission Screening and Resident Review PASARR Level II. Review of Resident #27's Annual MDS, with an ARD of 8/13/2019, coded Resident #27 as having a diagnosis of Bipolar disorder. During an interview on 10/2/2019 at 2:39 PM, Social Worker #1, stated, "There are no Level II's	F 644	both of these residents. * All residents have the potential to be affected by this alleged deficient practice. * Beginning 10/28/19, the Social Worker will track the diagnoses and subsequent status changes of residents. A Referral for PASARR Level II Log was created for this purpose. This information will be presented at the weekly Quality Assurance Review to ensure timeliness of referral and appropriateness of residents within the facility. The Social Service Director and MDS nurse received education and information, via phone, from Ascend on 10/28/19. The Administrator also provided education on F644 Coordination of PASARR and Assessments on 10/28/19. * The PASARR Level II Tracking Log will be submitted by the Social Services Director into the Quarterly Quality Assurance Review for further review, recommendations, and changes as needed. This plan of correction is integrated into the Quality Assurance system.	

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F 644	Continued From page 9 because they were taught in training if they had a diagnosis of Alzheimer's disease they did not need a Level 2.	F 644		

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	25A416	A. BUILDING **01 - BEDFORD ALZHEIMER S CARE CENTER, LLC** B. WING _____	**10/04/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect all the generator's required components as directed by NFPA 110 section 5.6.6 and NFPA 99 section 6.4.1.1.17. This deficiency had the potential to affect all residents in the facility at the time of survey. Findings include: On October 3, 2019 at 10:50 AM, observation revealed no remotely located annunciator panel for the temporary generator operating in the facility. The annunciator panel shall be in a continuous supervised location of the facility.	K 916	Bedford Alzheimer's Care Center, LLC acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations please accept this Plan of Correction as our allegation of compliance. Bedford Alzheimer's Care Center, LLC response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.	12/12/19

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

Electronically Signed | 11/01/2019

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.

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K 916	Continued From page 1	K 916	* On 10/31/2019, an order for a new generator was executed by Bedford Alzheimer's Care Center. The new generator will have a remote annunciator that is storage battery powered and will be located outside of the generating room in a location that is visible by personnel. * All residents have the potential to be affected by this alleged deficit * Weekly inspections will be conducted by the Maintenance Director, or designee to insure the generator annunciator is in proper working order. * The weekly generator annunciator inspections will be integrated into the Quality Assurance review to insure proper protection and operation of the generator's required components. This plan of correction is integrated into the Quality Assurance System.	

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 _____	10/04/2019

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) COMPLETION DATE
E 000	Initial Comments ********** Survey conducted on 10/04/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 11/01/2019

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.