STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 complaint investigations (CI-MS #15921 and CI MS #16169) on 8/20/2019- 8/21/2019 in your facility. The result of the investigation for MS #15921 was unsubstantiated for Quality of Care, with no deficiencies cited. The result of the investigation for MS #16169 was substantiated with regulatory deficiencies cited at F600. The facility was found not to be in compliance with requirements of participation for Medicare and Medicaid. The census at the time of survey was 76, with a license for 80 beds.	F 000		
F 600 SS=D	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: Based on observation, record review, facility policy review, and staff interview, the facility failed to protect the resident from verbal and	F 600	Bedford Care Center- Monroe Hall, LLC acknowledges receipt of the Statement of Deficiencies and proposes this Plan of	10/1/19

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

Electronically Signed | 09/19/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 600	Continued From page 1 physical abuse for one (1) of five (5) residents reviewed for abuse. (Resident #1) Findings include: Review of the facility policy titled, "Abuse Prevention Program," dated July 2019, revealed that it is the policy of this facility that the residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Review of an "Alleged Abuse Incident Report", dated 8/19/19, revealed Certified Nursing Assistant (CNA) #1 witnessed CNA #2 call Resident #1, a "crazy ass bitch" and slap the resident on the right arm. Resident #1 was assessed with no injury and was unable to give a statement due to a cognitive diagnosis of Dementia. The facility's investigative report, attached to the incident report, documented CNA #2 was sent home pending investigation, and the local and state authorities were notified. Review of a hand-written statement by CNA #1, dated 8/19/2019, revealed that she witnessed CNA #2 state to Resident #1, "You crazy ass bitch." The statement documented CNA #2 went around to the right side of the resident's bed and popped the resident on her arm. A hand-written statement dated 8/19/19, documented by RN #1, revealed CNA #2 told her she was mad because Resident #1 was fighting her and pinching her breast. The CNA denied hitting the resident, but did not address the verbal statement to the resident. During observations, on 8/20/2019 at 2:50 PM, and again on 8/21/19 at 10:00 AM, Resident #1	F 600	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 credible allegation of compliance. Bedford Care Center- Monroe Hall, LLC's response to this Statement of Deficiencies does not denote aggreement with the Statment of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Resident #1 was assessed for any psychosocial and physical harm, by the Registered Nurse, Unit Manager immediately following the incident on 8/16/19. There was no psychosocial or physical harm substantiated. The Certified Nursing Assistant #2 was immediately removed from assigned residents by the Registered Nurse, Unit Manager and sent home until further notice from the Administrator. The Certified Nursing Assistant #2 never returned for the disciplinary action meeting and was terminated on 8/21/19. All residents have the potential to be affected by the alleged deficient practice. Therefore, all residents that CNA#1 was assigned was interviewed for any psychodocial harm or related problems. There were no problems noted from any other residents. -An inservice on preventing and reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 600	Continued From page 2 was sitting in the wheelchair in her room. On 8/20/19, Resident #1 was cognitively impaired and only stated, "What?", when asked about the alleged incident in which she was hit and cursed at by a CNA. Resident #1 had no bruising or signs of physical injury and did not appear to be in any distress or discomfort during either observation. During an interview, on 8/20/2019 at 2:35 PM, the facility's Administrator revealed that he had been made aware of an incident where CNA #2 was witnessed to be verbally and physically abusive to one of the residents. The Administrator stated that CNA #2 had not returned to work since the incident occurred. During an interview, on 8/20/2019 at 3:05 PM, Registered Nurse (RN) #1/ Shift Supervisor, stated that she was called to the area of Resident#1's room from the dining room on 8/16/2019, where CNA #1 reported she witnessed CNA #2 curse and slap Resident #1. RN #1 stated that she told CNA #2 to go to the facility's Family Room and stay there until she returned. RN #1 stated she notified the Director of Nursing (DON), Resident #1's family, the on-call Nursing Practitioner (NP), and the Mississippi State Department of Health (MSDH) of the allegation. RN #1 stated that she advised CNA #2 to leave the building immediately and called the local law enforcement office, but CNA #2 left the property before the Sheriff's Department arrived. During an interview, on 8/20/2019 at 3:30 PM, CNA #1 revealed that she had witnessed CNA #2 cursing at Resident #1 saying ,"You crazy ass bitch." CNA #1 stated, that CNA #2 walked around to the right side of the resident's bed and	F 600	abuse, neglect, and exploitation was immediately conducted by the Registered Nurse, Unit Manager on 8/16/19 for all employees present. An inservice was conducted by the Registered Nurse, Unit Managers and Staff Development Registered Nurse for all employees and all contract staff by 8/21/19. Our facility's 2019 Education Plan has been updated to include preventing and reporting abuse, neglect, exploitation of vulnerable adults every six(6) months, which previously was required annually and conducted by the Social Services Director. Training regarding burnout and stress for employees has also been increased to every six(6) months that will be held by the Staff Development Registered Nurse. The facility's contracted Employee Assistance Program, through a local hospital, will provide our facility with trainings quarterly to include mental health, dealing with combative residents and other related topics as needed. The 2019 Education Plan and Inservices will be submitted at least quarterly to the Quality Assessment and Assurance Committee with the Medical Director and the Quality Assurance Performance Improvement Steering Committee for their review and and recommendations or suggestions for sustaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 600	Continued From page 3 slapped the resident on the arm. CNA #1 stated she told CNA #2 that she should not have done that. CNA #1 stated that she then left the room and called the Nurse Supervisor and reported the incident to her. During an interview, on 8/20/2019 at 3:48 PM, Registered Nurse (RN) #2 confirmed that he was working on the evening of 8/16/2019. RN #2 stated that he was at the nurses' station, when the floor nurse and CNA #1 called him to come down the hall. RN #2 stated that CNA #1 reported to him that she had witnessed CNA #2 call Resident #1 a "crazy ass bitch" and hit her on the arm. RN #2 stated that he went to the room where CNA #2 was assisting another resident, and told her to go out into the hall and talk to RN #1. RN #2 stated he assessed Resident #1 for injuries and checked to see if she was alright. RN #2 stated that he didn't see any bruising or other injuries. RN #2 stated that he assessed each resident that had been assigned to CNA #2 and did not find any resident with any injuries. RN #2 stated that he had interviewed all of the residents that were cognitively able to answer, asking them if anyone had verbally or physically abused them. RN #2 stated, "None of the residents said they had been abused." During an interview on 8/20/2019 at 4:30 PM, the facility's Administrator stated he had spoken to CNA #2 on the phone, who was very distraught, saying that she was so sorry, and confessed to cursing and hitting Resident #1. The Administrator stated he requested that CNA #2 come to the facility to talk to him concerning the incident and CNA #2 agreed. The Administrator stated that the meeting with CNA #2 was going to be at 11:00 AM on 8/21/2019.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 600	Continued From page 4 During an interview on 8/21/2019 at 11:30 AM, the facility Administrator stated that CNA #2 did not show up for the meeting that had been set for 11:00 AM. The Administrator stated that he had initiated the official termination of employment of CNA #2 for abuse of Resident #1. Review of the facility's personnel document titled, "Acknowledgement of Employment Information," dated 6/21/2019, revealed that CNA #2 had initialed the section for Abuse-Vulnerable Persons/Elder Justice Act, indicating that she had received, read, and understood the information. Review of the Face Sheet revealed Resident #1 was admitted by the facility on 9/7/2018, with diagnoses to include Dementia with behavioral disturbances, Diabetes Mellitus Type Two (2), and Chronic Kidney Disease.	F 600		

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
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 complaint investigations (CI-MS #15921 and CI MS #16169) on 8/20/2019- 8/21/2019 in your facility. The result of the investigation for MS #15921 was unsubstantiated for Quality of Care, with no deficiencies cited. The result of the investigation for MS #16169 was substantiated for abuse with regulatory deficiencies cited: M500. The facility was found not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The census at the time of survey was 76, with a license for 80 beds.	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	M 500		10/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 1 medical care, is fully informed by a physician or 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,	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 2 discrimination, or reprisal; 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;	M 500		

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
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 3 12. may associate and communicate privately 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 II	M 500	Bedford Care Center- Monroe Hall, LLC	

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
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 4 Based on observation, record review, facility policy review, and staff interview, the facility failed to protect the resident from verbal and physical abuse for one (1) of five (5) residents reviewed for abuse. (Resident #1) Findings include: Review of the facility policy titled, "Abuse Prevention Program," dated July 2019, revealed that it is the policy of this facility that the residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Review of an "Alleged Abuse Incident Report", dated 8/19/19, revealed Certified Nursing Assistant (CNA) #1 witnessed CNA #2 call Resident #1, a "crazy ass bitch" and slap the resident on the right arm. Resident #1 was assessed with no injury and was unable to give a statement due to a cognitive diagnosis of Dementia. The facility's investigative report, attached to the incident report, documented CNA #2 was sent home pending investigation, and the local and state authorities were notified. Review of a hand-written statement by CNA #1, dated 8/19/2019, revealed that she witnessed CNA #2 state to Resident #1, "You crazy ass bitch." The statement documented CNA #2 went around to the right side of the resident's bed and popped the resident on her arm. A hand-written statement dated 8/19/19, documented by RN #1, revealed CNA #2 told her she was mad because Resident #1 was fighting her and pinching her breast. The CNA denied hitting the resident, but did not address the verbal statement to the resident.	M 500	acknowledges receipt of the 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 credible allegation of compliance. Bedford Care Center- Monroe Hall, LLC's response to this Statement of Deficiencies does not denote aggreement with the Statment of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Resident #1 was assessed for any psychosocial or physical harm, by the Registered Nurse, Unit Manager immediately following the incident on 8/16/19. There was no psychosocial or physical harm substantiated. The Certified Nursing Assistant #2 was immediately removed from assigned residents by the Registered Nurse, Unit Manager and sent home until further notice from the Administrator. The Certified Nursing Assistant #2 never returned for the disciplinary action meeting and was terminated on 8/21/19. All residents have the potential to be affected by the alleged deficient practice. Therefore, all residents that CNA#1 was assigned was interviewed for any psychodocial harm or related problems. There were no problems noted from any other residents. -An inservice on preventing and reporting	

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
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 5 During observations, on 8/20/2019 at 2:50 PM, and again on 8/21/19 at 10:00 AM, Resident #1 was sitting in the wheelchair in her room. On 8/20/19, Resident #1 was cognitively impaired and only stated, "What?", when asked about the alleged incident in which she was hit and cursed at by a CNA. Resident #1 had no bruising or signs of physical injury and did not appear to be in any distress or discomfort during either observation. During an interview, on 8/20/2019 at 2:35 PM, the facility's Administrator revealed that he had been made aware of an incident where CNA #2 was witnessed to be verbally and physically abusive to one of the residents. The Administrator stated that CNA #2 had not returned to work since the incident occurred. During an interview, on 8/20/2019 at 3:05 PM, Registered Nurse (RN) #1/ Shift Supervisor, stated that she was called to the area of Resident#1's room from the dining room on 8/16/2019, where CNA #1 reported she witnessed CNA #2 curse and slap Resident #1. RN #1 stated that she told CNA #2 to go to the facility's Family Room and stay there until she returned. RN #1 stated she notified the Director of Nursing (DON), Resident #1's family, the on-call Nursing Practitioner (NP), and the Mississippi State Department of Health (MSDH) of the allegation. RN #1 stated that she advised CNA #2 to leave the building immediately and called the local law enforcement office, but CNA #2 left the property before the Sheriff's Department arrived. During an interview, on 8/20/2019 at 3:30 PM, CNA #1 revealed that she had witnessed CNA #2 cursing at Resident #1 saying ,"You crazy ass	M 500	abuse, neglect, and exploitation was immediately conducted by the Registered Nurse, Unit Manager on 8/16/19 for all employees present. An inservice was conducted by the Registered Nurse, Unit Managers and Staff Development Registered Nurse for all employees and all contract staff by 8/21/19. Our facility's 2019 Education Plan has been updated to include preventing and reporting abuse, neglect, exploitation of vulnerable adults every six(6) months, which previously was required annually and conducted by the Social Services Director. Training regarding burnout and stress for employees has also been increased to every six(6) months that will be held by the Staff Development Registered Nurse. The facility's contracted Employee Assistance Program, through a local hospital, will provide our facility with trainings quarterly to include mental health, dealing with combative residents and other related topics as needed. The 2019 Education Plan and Inservices will be submitted at least quarterly to the Quality Assessment and Assurance Committee with the Medical Director and the Quality Assurance Performance Improvement Steering Committee for their review and and recommendations or suggestions for sustaining compliance.	

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
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 6 bitch." CNA #1 stated, that CNA #2 walked around to the right side of the resident's bed and slapped the resident on the arm. CNA #1 stated she told CNA #2 that she should not have done that. CNA #1 stated that she then left the room and called the Nurse Supervisor and reported the incident to her. During an interview, on 8/20/2019 at 3:48 PM, Registered Nurse (RN) #2 confirmed that he was working on the evening of 8/16/2019. RN #2 stated that he was at the nurses' station, when the floor nurse and CNA #1 called him to come down the hall. RN #2 stated that CNA #1 reported to him that she had witnessed CNA #2 call Resident #1 a "crazy ass bitch" and hit her on the arm. RN #2 stated that he went to the room where CNA #2 was assisting another resident, and told her to go out into the hall and talk to RN #1. RN #2 stated he assessed Resident #1 for injuries and checked to see if she was alright. RN #2 stated that he didn't see any bruising or other injuries. RN #2 stated that he assessed each resident that had been assigned to CNA #2 and did not find any resident with any injuries. RN #2 stated that he had interviewed all of the resident that were cognitively able to answer, asking them if anyone had verbally or physically abused them. RN #2 stated, "None of the residents said they had been abused." During an interview on 8/20/2019 at 4:30 PM, the facility's Administrator stated he had spoken to CNA #2 on the phone, who was very distraught, saying that she was so sorry, and confessed to cursing and hitting Resident #1. The Administrator stated he requested that CNA #2 come to the facility to talk to him concerning the incident and CNA #2 agreed. The Administrator stated that the meeting with CNA #2 was going to	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18BC	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 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 7 be at 11:00 AM on 8/21/2019. During an interview on 8/21/2019 at 11:30 AM, the facility Administrator stated that CNA #2 did not show up for the meeting that had been set for 11:00 AM. The Administrator stated that he had initiated the official termination of employment of CNA #2 for abuse of Resident #1. Review of the facility's personnel document titled, "Acknowledgement of Employment Information," dated 6/21/2019, revealed that CNA #2 had initialed the section for Abuse-Vulnerable Persons/Elder Justice Act, indicating that she had received, read, and understood the information. Review of the Face Sheet revealed Resident #1 was admitted by the facility on 9/7/2018, with diagnoses to include Dementia with behavioral disturbances, Diabetes Mellitus Type Two (2), and Chronic Kidney Disease.	M 500		