STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015031	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell-Hollingsworth Nursing & Rehabilitation	805 Flagg Circle Florence, AL 35631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, document review, and policy review, the facility failed to ensure that one of six residents (Resident (R) 137) reviewed for abuse, was free from abuse of 38 sample residents. This failure had the potential to affect resident safety. Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated [DATE], recorded It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.1.Review of R137's undated admission Record located in the electronic medical record (EMR) under the Profile tab, indicated R137 was initially admitted to the facility on [DATE], and readmitted [DATE] with diagnoses including Alzheimer's disease, dementia, major depressive disorder, psychotic disorder with delusions due to known physiological condition, and type two diabetes.Review of R137's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating R137 was severely cognitively impaired, and exhibited no behaviors.Review of R137's Care Plan, dated [DATE], with revision date of [DATE], located in the EMR under the Care Plan tab, revealed R137 is on Behavior Management Program monitored on Behavior Monitoring Record. Behaviors are: resident wanders into others resident room, laying in their beds, exit seeks, Resident believes that [he/she] talking to someone when talking to pictures on the wall, believes that it is someone else when looking into a mirror, thinks [he/she] is younger, Disrobing, voiding in inappropriate places, and will push other residents in their chairs and they don't want [his/her] to. Resident does not know personal space, invade the personal boundaries of others without permission. Interventions include: Call family to assist with redirection, Check code alert bracelet weekly for functioning status and daily for placement, Code alert bracelet applied to alert staff of unsafe wandering attempts, Decrease the frequency of behavioral episodes to once a month, If resident is wandering , take [his/her] to the bathroom, Resident receives services from [Name] Behavioral Health, Take resident for a walk off of unit around the building, Take resident on the screen in porch if weather permits, watch for resident if invading another resident's personal space. Approach in a calm manner and introduce yourself, explain tasks and importance of care, and reassure the resident that they are safe, and we are here to help [his/her].2. Review of R220's undated admission Record located in the EMR under the Profile tab, indicated R220 was initially admitted to the facility on [DATE], with a readmission on [DATE], and expired on [DATE]. Diagnoses included senile degeneration of brain, neurocognitive disorders with Lewy bodies, dementia with mood disorder, agitation, and anxiety, and psychotic disorder with delusions.Review of R220's quarterly MDS with an ARD of [DATE], located in the EMR under the MDS tab revealed a BIMS score of three out of 15, indicating the resident was severely cognitively impaired. R220 was assessed as experiencing hallucinations, delusions, and wanders one to three days out of the seven days look back period.Review of R220's Care Plan, dated [DATE], located in the EMR under the Care Plan tab, revealed R220 is on Behavior Management Program monitored on Behavior Monitoring (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record-Behaviors are wander into others' room and exit seek; rejection of care; physical behaviors directed towards others, and verbal behaviors. Interventions included .Approach in a calm manner and introduce yourself, Explain tasks and importance of care, Reassure resident that they are safe and we are here to help them, Validate feelings and redirect thoughts if possible/appropriate, Praise efforts and cooperation, Give choices if possible, Assess for basic needs (comfort, pain, hunger, thirst, toileting, needs, etc.), Make sure resident is safe and return later to attempt tasks as needed, remove from excess stimulation and provide 1:1 attention asneeded, walk with resident if wandering and redirect thoughts to a different subject; return to station/room, contact resident rep, resident services director, mental health, therapist, family, or sponsor as needed, contact physician for as needed (PRN) medication if above interventions are not successful.Review of the facility's Resident Abuse, Neglect, and Unusual Occurrence Report, Detailed Investigation, dated [DATE], provided by the facility, revealed On [DATE] at approximately 11am [R220] and [R137] were standing in the hallway when [Certified Nurse Aide (CNA) 5] heard [R137] raise [his/her] voice which caused her to look around the corner from the nursing desk and witnessed [R220] hit [R137] in the face which resulted in [his/her] stumbling backwards into a resident's room without falling. CNA assisted [R137] while [R137] was holding [his/her] face oh it hurts. CNA noticed a red area above her lip. Resident Assistant who also responded to the residents walked with [R220] and did not leave [his/her] side assisted with [R137's] care. Intervention: Staff immediately intervened and removed both residents safely away from each other and attended to both simultaneously. [R137] was assessed and treated with a cold pack on [his/her] lip, physician and family notified. [R220] was assigned 1:1 care until [he/she] transferred to an acute care facility for continued assessment and treatment. [R220] was admitted to the [Name] for further assessment and treatment. Based on findings from the statements, eyewitnesses, interviews and resident's history, it was concluded that there was a resident-to-resident altercation of Abuse-Physical between said residents. During an interview on [DATE] at 2:48 PM, the Director of Nursing (DON) stated he recalled this incident, unsure what caused it, but resident had behaviors including wandering. DON added it was witnessed by the CNA. CNA5 and the Resident Assistant were unavailable for interview.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, interview, and policy review, the facility failed to ensure one of five residents (Resident (R) 7) reviewed for unnecessary medications had an appropriate diagnosis for the use of an atypical antipsychotic medication with dementia of 38 sample residents. Findings include:Review of the facility's policy titled, Use of Psychotropic Medications, reviewed 04/22/25, revealed: Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and/or pharmacy journals.Review of the facility's policy titled, Addressing Medication Regime Review Irregularities, reviewed 10/24/24, revealed: Policy: The facility should provide timely responses to irregularities identified as a result of a resident's medication regimen review (MRR). Irregularity refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy.Review of R7's admission Record from the electronic medical record (EMR) Profile tab revealed a facility admission date of 07/23/25 with medical diagnoses that included pelvic fracture, dementia without behavioral disturbance, delirium, somnolence, lack of coordination, altered mental status, and restlessness and agitation.Review of R7's Order Summary from the EMR Orders tab revealed orders for: -Quetiapine (an atypical antipsychotic medication, brand name Seroquel) 100 milligrams (mg) at bedtime related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, ordered on 08/14/25 and -Seroquel 25mg (generic name Quetiapine) daily related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, ordered on 09/02/25. During an interview on 09/18/25 at 4:25 PM, the Quality Improvement Registered Nurse (QIRN) provided a physician signed document, dated 07/22/25, with an applicable diagnosis for atypical antipsychotics for residents with dementia. Review of the document, provided by the facility, revealed, [R7's name] is prescribed Seroquel for Dementia with behavioral disturbances.The Director of Nursing (DON) provided a list of Consultant Pharmacist medication reviews completed on 08/11/25 and 09/11/25 that revealed no recommendations were made regarding R7's use of an atypical antipsychotic medication.During an interview on 09/18/25 at 5:58 PM regarding the August 2025 and September 2025 Pharmacist medication reviews and the dementia without behavioral issues diagnosis in the EMR for the atypical antipsychotic prescription, the DON stated an expectation that the Pharmacist would identify the discrepancy and noted She (Consulting Pharmacist) normally does look at the diagnosis to be sure they are appropriate. The Pharmacist was unavailable for interview. Review of the National Institute of Health (NIH) article titled, Atypical Antipsychotic use in Patients with Dementia: Managing Safety Concerns located at https://pmc.ncbi.nlm.nih.gov/articles/PMC3516138/, published 09/12, revealed: In the elderly population, the largest number of prescriptions for atypical antipsychotics is written for the neuropsychiatric symptoms (NPS) of dementia (1). NPS (e.g., delusions, depression, agitation) affect up to 97% of people with dementia over the course of their illness (2). No atypical antipsychotic is FDA-approved for the treatment of any NPS in dementia.The 2012 American Geriatric Society (AGS) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Beers consensus criteria for safe medication use in the elderly (7) recommend avoiding antipsychotics to treat NPS of dementia due to the increased mortality and CVAE [cardiovascular adverse events] risk unless nonpharmacological options have failed and patient is threat to self or others. Additional adverse effects include cardiovascular and metabolic effects, extrapyramidal symptoms, cognitive worsening, infections, and falls.Review of the NIH article titled, FDA [Food and Drug Administration] warns about using antipsychotic drugs for dementia located at https://pmc.ncbi.nlm.nih.gov/articles/PMC556368/#:~:text=The%20US%20Food%20and%20Drug,stroke%2C corrected on 05/28/05, revealed The FDA asked manufacturers to place a black box warning on drug labels-indicating an adverse reaction that may result in death or serious injury-noting the increased death rates and that these drugs are not approved for the treatment of behavioral symptoms in elderly patients with dementia. The drugs affected include aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), clozapine (Clozaril), and ziprasidone (Geodon). A drug used for depression associated with bipolar disorder, olanzapine (Symbyax), was included in the advisory warning.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure two of three residents (Resident (R) 3 and R12) Resident Representative (RR) or Family Member (FM) reviewed for facility initiated emergent transfer to the hospital received a written notice of transfer and/or a written bed hold notice from a sample of 38 residents. This failure had the potential to affect the resident and their Resident Representative by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired, and contribute to the possibility of denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include:Review of the facility's policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), reviewed 09/22/22, revealed: Policy Explanation and Compliance Guidelines.4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing f. request. h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations. 1. Review of R3's admission Record from the electronic medical record (EMR) Profile tab revealed a facility admission date of 10/11/24, readmission on [DATE], with medical diagnoses that included intervertebral disc degeneration, back pain, tremors, fall history, weakness, history of poliomyelitis, generalized muscle weakness, difficulty in walking, altered mental status, and restlessness and agitation. A review of R3's EMR Progress Notes tab revealed: Effective Date: 07/19/2025 12:55 [PM] Type: FALL DOCUMENTATION Note Text: Called to patient's room by another LPN [Licensed Practical Nurse] ([name]). She states the patient fell. Upon entering the patient's room, the patient was in [sic] the floor just inside the door and laying slightly to the left side in a semi sitting position. [He/She] was assisted into wheelchair x 2 and complains of left hip and elbow pain. Charge nurse ordering x rays. [Practitioner name] notified. 07/19/2025 14:30 [2:30 PM] General Nurse's Note Text: Pt [Patient] left facility via EMS [Emergency Medical Services to [Hospital name]. A review of R3's EMR Miscellaneous tab revealed a transfer/discharge notice, dated 07/19/25, that showed the resident was unable to sign and the box for the form being mailed to the RR or FM was not checked. 2. Review of R12's admission Record from the EMR Profile tab revealed the latest facility admission date of 07/23/25 with medical diagnoses that included critical illness myopathy, recurrent pneumonia, type II diabetes, anxiety, venous embolisms, osteoarthritis, and fibromyalgia. A review of R12's EMR Progress Notes tab revealed R12 had been sent to the hospital on [DATE] for sepsis, 05/28/25 for purulent drainage around a feeding tube site, 06/03/25 for an unresponsive episode, and 07/18/25 for altered mental status with diaphoresis. Review of R12's EMR Miscellaneous tab revealed transfer notices for the above dates but no evidence that the notices had been provided to the RR or FM. During an interview on 09/17/25 at 3:51 PM, the Quality Improvement Registered Nurse (QIRN) stated nothing was provided in writing to the RR/FM, but the family was always called and was aware of the transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The QIRN reviewed the transfer notices for R3 and R12 and confirmed the box at the bottom of the forms, that the form had been mailed out, was not checked. During a telephone interview on 09/18/2025 at 2:42 PM regarding receipt of the written notice of transfer and/or discharge, R12's RR/FM (FM12) stated, I'm in communication with them [facility] on the phone or while I'm there. They contact me regularly. When clarified about a written notice for the dates of emergent transfer, FM12 stated Those were all emergent, so I wasn't there to receive anything in writing. FM12 clarified that nothing had been mailed, and she had not been provided with anything in writing. During an interview on 09/18/25 at 5:43 PM regarding the emergent transfer process, Registered Nurse (RN) 1 stated, I call the physician, then call 911, then call the family to let them know. Get our transfer paperwork, the bed hold agreement; prepare the transfer paperwork [clarified document for EMS and EMS signs the last page for our records as to who took the resident]. Print off three of them, one for EMS, one for the ER, and one for us to keep. Then I call report to hospital when EMS gets here, take down the information of who I reported to in ER. When asked if anything was given to the patient in writing, RN1 responded They take the bed hold agreement and it has transfer information on the back, it goes with the hospital documentation. When the patient family goes to see the patient or comes back here, we can give them a copy. RN1 was not aware of anything being provided to the family unless they came in to get it.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, facility failed to conduct a thorough falls root cause analysis for two of eight residents (Residents(R) 137 and R3) reviewed for falls of 38 sample residents. This failure could result in the facility's inability to discover the reason behind the resident's fall and put the appropriate interventions in place based on the reason for the fall.Findings include:Review of the facility's policy titled, Fall Prevention Program, dated 11/20/24, recorded When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the residents' care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. h. Initiate an intervention as appropriate to the cause of the fall to reduce the opportunity for a fall to recur.1.Review of R137's undated admission Record located in the EMR under the Profile tab, indicated R137 was initially admitted to the facility on [DATE], and readmitted [DATE] with diagnoses including Alzheimer's disease, dementia, and osteoarthritis.Review of R137's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/19/23, located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score three out of 15, indicating R137 was severely cognitively impaired, and exhibited no behaviors. R137 was independent with bed mobility, transfers, walking in room and in corridor. R137 required extensive assistance from two staff members for dressing, toilet use, and personal hygiene.Review of R137's Care Plan, dated 11/10/21, located in the EMR under Care Plan tab, revealed Potential for falls related to dementia, poor safety awareness, psychotropic medication, wandering, pain, anemia. Interventions included attempt to ensure resident wearing own appropriate footwear while ambulating (Resident often removes), attempt to keep as safe as possible, attempt to keep wheeled chairs out of day area when not in use, bring resident out to day area when restless, ensure resident has on non-skid shoes daily, mattress to be taken out of room, monitor resident gait and balance, monitor resident when ambulating and remind [his/her] to walk slower so [she/he] does not trip on [his/her] own feet, therapy evaluation initiated, administer medications as ordered and monitor for possible side effects that could contribute to falls (dizziness, drowsiness, weakness, hypotension, etc.), Ensure all fall precautions are in place, ensure resident has non-skid footwear that fits adequately, keep frequently used items within easy reach, keep gripper socks or non-skid shoes on as tolerated by resident, keep pathways well-lit and clutter free, keep resident's adjustable bed in the lowest position with the wheels locked, keep resident's call light accessible and answer calls in a timely manner, notify physician and resident's sponsor if resident has a fall and any injuries if they occur, assist with toileting as needed, monitor falls and safety issues, provide cueing and supervision as needed, and silent bed alarm placed to alert staff of unsafe transfers.Review of the facility's Fall Incident Report, provided by the facility and dated 08/29/25, recorded R137 observed lying on floor with head facing the door and feet facing the bed. [R137] noted to be dressed and dry. [R137] noted to have non-skid socks in place. [R137] alert with confusion. [R137] yells out when moved. [R137] roommate states that resident fell. Transferred to emergency room (ER) for evaluation and treatment. Right trochanter fracture.Review of the facility's Root Cause Analysis, dated 09/02/25, recorded Change in Care/Action: X-rays ordered by Medical Doctor (MD), x-ray obtained 08/29/25 at 12:20 PM, x-ray reveals acute non-displaced right femoral intertrochanteric fracture. MD and family notified of findings-order given to transfer to ER, resident admitted to hospital for management of fracture. Silent bed alarm added to be to alert staff of unsafe transfers. There was no investigation into the cause of R137's fall. During an interview on 09/18/25 at 4:57 PM, Licensed Practical Nurse (LPN) 3 was questioned if she had witnessed R137's fall. LPN3 stated that No, I got to work at 6:30 AM and [R137's] call light was on. I went to [his/her] room and saw [R137] on the floor, when I tried moving (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[his/her], [she/he] cried out ow, ow and gripped [his/her] hips. Notified physician and family, physician ordered transfer to hospital. Roommate said [R137] fell. LPN3 was asked if she thought that R137's roommate was cognitive enough to know R137 fell. LPN3 stated Yes, I believe [his/her] roommate was aware enough to know [she/he] fell and turned the call light on.2. Review of R3's admission Record from the EMR Profile tab revealed a facility admission date of 10/11/24, readmission on [DATE], with medical diagnoses that included intervertebral disc degeneration, back pain, tremors, fall history, weakness, history of poliomyelitis, generalized muscle weakness, difficulty in walking, altered mental status, and restlessness and agitation.Review of R3's EMR Progress Notes tab showed: 07/19/2025 12:55 [PM] Fall Documentation. Note Text: Called to patient's room by another LPN [Licensed Practical Nurse] (name in parentheses). She states the patient fell. Upon entering the patient's room, the patient was in the floor just inside the door and laying slightly to the left side in a semi sitting position. [He/She] was assisted into wheelchair x 2 and complains of left hip and elbow pain. Charge nurse ordering x rays. [Practitioner Name] notified. 07/19/2025 14:30 [2:30 PM] General Nurse's Note. Note Text: PT [patient] left facility via EMS [Emergency Medical Services] to [Hospital identified].A request for the fall investigation yielded a Witnessed Fall incident report that did not give a plausible explanation for the fall. A second request was made for the fall investigation, and the facility provided a Root Cause Analysis document.Review of the facility provided Root Cause Analysis Resident QI [Quality Improvement] Details, document regarding R3's fall, dated 08/19/25, revealed: Findings. [Staff member name] was called to residents room by LPN [Name]. She stated the patient fell. Upon entering the patients room, the patient was in [sic] the floor just inside the door and laying slightly to the left side of the door in a semi sitting position. Assist to wheelchair x2 assist. [He/She] is c/o [complaint of] left hip pain and elbow pain. Notified [his/her] charge nurse and xrays are being ordered. [Practitioner Name] notified. Change in Care/Action. Assisted to wheelchair x2 assist. Pt left facility via EMS and admitted with left hip fracture. After return from hospital resident relocated to room across from nurses desk, bed alarm added to bed. Intervention in place to have resident up in day area when out of bed and no sitter present. Expected Outcome. Patien [sic] to return to facility. Left hip to heal and care to continue.On 09/17/25 at 4:30 PM, the Director of Nursing (DON) reviewed the Root Cause Analysis [RCA] and confirmed there was no cause of the fall identified on the RCA and there were no witness statements included.During an interview on 09/18/25 at 5:51 PM regarding the Root Cause Analysis, the DON stated, It's very important how a fall occurred to set an intervention to keep it from happening again. We only do RCAs on falls with major injuries.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, record review, and facility policy review, the facility failed to ensure alternatives were attempted prior to the use of side rails for two of two residents (Resident (R) 7 and R12) reviewed for side rails out of 38 sample residents. This failure had the potential to increase accidental entrapment or injury from bed rail usage when an alternate assistive device may have been effective.Findings include:Review of the facility's policy titled, Proper Use of Bed Rails, reviewed 07/07/25, revealed: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails.Resident Assessment: .2. The resident assessment may include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Resident and family preference for the use of side rails, excluding full length rails, to assist with bed mobility or positioning will be honored. Appropriate Alternatives 9. The facility may attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to: a. Roll guards b. Foam bumpers c. Lowering the bed d. Concave mattresses 10. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered. 11. If no appropriate alternatives are identified, the medical record should include evidence of the following: a. Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful b. Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight), and c. Risks and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use.1. Review of R7's admission Record from the electronic medical record (EMR) Profile tab revealed a facility admission date of 07/23/25 with medical diagnoses that included pelvic fracture, dementia, delirium, somnolence, lack of coordination, altered mental status, and restlessness and agitation.Review of R7's EMR admission Minimum Data Set (MDS) tab with an Assessment Reference Date (ARD) of 07/29/25 revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, indicative of severe cognitive impairment.Observations on 09/16/25 at 3:03 PM revealed R7 had bilateral upper bed rails on his bed. On 09/17/25 at 8:50 AM and 09/18/25 at 2:30 PM, R7 was observed in bed with the bed rails up. Review of R7's EMR Assessments tab revealed a Bed Side-Rail Safety Assessment, dated 08/05/25, that had blank fill in areas for: 10a. List side rail alternatives considered but not attempted because they were considered inappropriate for resident. 10b. List any Side Rail alternatives attempted that failed to meet resident's needs. However, 10c was checked that both the resident and family requested the use of bedside rails. Review of R7's EMR Care Plan tab revealed a focus, initiated 07/22/25, of Potential for injury from bed side rails related to: impaired mobility with a goal of: Resident will benefit from the use of bed side rails AEB [As Evidenced By]: no documented injury from side rails through the next review period. with interventions of: (1/4) bed rails for (safety, mobility, and weakness), 1 and/or 2 rails PRN [as needed] -Annual side rail safety inspection completed by maintenance staff. -Observe for and report loose rails, sharp edges, or other possible problems with side rails.-Observe for and report safety concerns or entrapment risks. 2. Review of R12's admission Record from the EMR Profile tab revealed the latest facility admission date of 07/23/25 with medical diagnoses that included critical illness myopathy, recurrent pneumonia, type II diabetes, anxiety, venous embolisms, osteoarthritis, and fibromyalgia. Review of R12's EMR quarterly MDS tab with an ARD of 08/25/25 revealed a BIMS score of 15 out of 15, indicative of being cognitively intact.Observation on 09/16/25 at 1:50 PM revealed R12 in bed with bilateral upper bed rails, and at 3:31 PM, R12 was out of his/her room but the bilateral bed rails were in the up position on the bed.Review of R12's EMR Assessment tab (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015031	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell-Hollingsworth Nursing & Rehabilitation	805 Flagg Circle Florence, AL 35631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed Bed Side-Rail Safety Assessments, dated 02/21/25, 03/12/25, 05/20/25, 05/30/25, 06/12/25, 07/03/25, and 08/05/25. All assessments were blank for 10a. List side rail alternatives considered but not attempted because they were considered inappropriate for resident and 10b. List any Side Rail alternatives attempted that failed to meet resident's needs with the exception of the 07/03/25 assessment which had N/A [not applicable] for both 10a and 10b.Review of R12's EMR Care Plan tab showed a focus, initiated 07/23/25, of Potential for injury from bed side rails related to: impaired mobility with a goal of Resident will benefit from the use of bed side rails AEB: no documented injury from side rails through the next review period with interventions of: -Annual side rail safety inspection completed by maintenance staff. -Observe for and report loose rails, sharp edges, or other possible problems with side rails.-Observe for and report safety concerns or entrapment risks. -Resident has left and right 1/4 length side rails for bed mobility and transfers; 1 and/or 2 rails PRN. -Side rails provide a feeling of comfort and security for resident. -Side rails provide a hand-hold for getting in and out of bed and during transfers. During an interview on 09/17/25 at 3:51 PM, the Quality Improvement Registered Nurse (QIRN) stated the facility reviewed the risk/benefits with the family ensuring the family understands the government says there could be entrapment but if they request side rails they get them. The QIRN continued on to say it was a resident's rights issue to have side rails if requested. At 5:01 PM, the QIRN provided the facility policy and stated she was sure the facility would be updating things as she reviewed the regulations and resident rights don't trump the regulation.In an interview on 09/18/25 at 5:56 PM regarding bed rail use expectations, the Director of Nursing (DON) stated, A lot of patients and families prefer to have rails, a lot use for mobility and bed controls hang there. When asked to clarify about attempted alternatives prior to the use of rails, the DON responded, We really never have in the past, never heard them [family/ residents] expressed desire for alternate other than a bed rail.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, product review, and policy review, the facility failed to ensure expired medications were not available for resident use in the medication room refrigerator for one of three medication rooms (200-hall) reviewed for medications. This had the potential to affect any of the 37 people residing on the 200 hall. Findings include:Review of the facility's policy titled, Medication Storage, reviewed 04/22/25, revealed:Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.Policy Explanation and Compliance Guidelines.8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.Observation of the 200 hall Medication Room on 09/18/25 at 11:00 AM with Licensed Practical Nurse (LPN) 4 revealed a tuberculin purified protein derivative (PPD) vial with an opened date on the box of 07/29/25 in the refrigerator. LPN4 verified the open date and then reviewed/ verified the side of the product box that stated after the vial had been entered it should be discarded after 30 days. At 11:04 AM, LPN4 then replaced the vial back in the refrigerator stated she would dispose of it properly later. During an interview on 09/18/25 at 5:50 PM, the Director of Nursing (DON) stated, [The PPD] Should have been moved to the dc'd [discontinued] meds. If not moved to dc meds, it may have been stored in the fridge, but it should not be available for resident use.