

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Bedford Care Ctr-Monroe Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Cahal Street Hattiesburg, MS 39401	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a resident was free from neglect, as evidenced by, on 10/21/24, at approximately 2:45 PM, after returning to an outing at a local fair, a resident was left in the facility's transportation van until approximately 5:00 PM, for one (1) of three (3) sampled residents. Resident #1</p> <p>Findings include:</p> <p>A review of the facility's policy, Abuse Prevention Program, modified 8/2/22, revealed .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .</p> <p>On 10/28/24 at 11:20 AM, during an interview with the Administrator, he stated that on 10/21/24, following a trip to a local fair, five (5) residents were in the facility's transportation van. At approximately 2:45 PM the van returned to the facility and all the residents were unloaded except Resident #1. The van driver, who is also responsible for central supply, was requested to retrieve supplies for another resident. The front desk staff reported she always had eyes on the resident, while the resident was in the van alone, which was approximately 20 minutes. The Administrator confirmed that the Director of Nursing (DON) called him on 10/21/24 and advised him that Resident #1 was found inside the facility van at approximately 5:00 PM. The Administrator also stated that although the facility had video surveillance, the surveillance system was not operational on 10/21/24.</p> <p>During an interview on 10/28/25 at 12:45 PM, the van driver stated that on 10/21/24 at approximately 2:45 PM, he arrived at the facility with five (5) residents. Resident #1 was the only resident who was in a wheelchair. During their return to the facility as the residents were exiting, the van driver was called to get supplies for another resident, leaving Resident #1 in the van. He stated he was only gone for five (5) to six (6) minutes. Front Desk #1 informed him that she would watch Resident #1 while he went for supplies. Upon returning to the van, he assisted Resident #1 off the van and brought him to the front lobby.</p> <p>On 10/28/24 at 12:55 PM, during an interview with Front Desk #1, she stated that while the van driver was getting supplies for another resident, she walked outside, then back inside, and kept eyes on Resident #1 the entire time he was in the van. Approximately 10 minutes later, the van driver returned and assisted the resident off the van.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 1:32 PM, during a phone interview with Registered Nurse (RN) #1/Supervisor, she stated that on 10/21/24 at approximately 5:00 PM during the evening meal, she was informed the facility staff could not locate Resident #1. RN #1 explained that all staff began to search for Resident #1, both inside and outside of the facility. Certified Nurse Assistant (CNA) #1 stated that Resident #1 went to the fair earlier and went to the front of the facility and found Resident #1 in the locked van. She further explained that Licensed Practical Nurse (LPN) #1 retrieved the facility van keys from Front Desk #1 and opened the van. The van driver had returned to the facility and assisted with removing Resident #1 from the van. RN #1 stated the incident was reported to the Director of Nurses (DON), and the Nurse practitioner (NP) was notified.</p> <p>During an interview on 10/28/24 at 2:01 PM with LPN #2, she confirmed that on 10/21/24 during dinner time at the facility, Resident #1 was not present in the dining room, the staff went to search for him and found him in the facility van. The van was locked, and LPN #1 received the keys from the front desk staff and opened the van. Someone had called the van driver back to the facility and he came and assisted in getting Resident #1 out of the van, which was at approximately 5:00 PM.</p> <p>On 10/28/24 at 2:10 PM, during a phone interview with CNA #1, she revealed that when she realized Resident #1 was not in the dining room during the evening meal, she remembered he had gone with the other residents to the local fair. She immediately went to the van, which was in the handicapped parking spot, and saw him inside the van. CNA #1 recalled that a nurse got the keys from the front desk staff and the van driver assisted with getting the resident off the van and into the facility.</p> <p>On 10/28/24 at 3:15 PM, during an interview with CNA #2, she stated that on 10/21/24 at approximately, 4:00 PM, she observed Resident #1 in the front lobby playing basketball.</p> <p>On 10/28/24 at 3:24 PM, during a phone interview with LPN #1, she stated that on 10/21/24, when the facility staff discovered that Resident #1 was missing, she searched his room and bathroom. When he was found to be locked in the facility van, she got the keys from the front office to get him out of the van. She said the van was parked in its designated parking spot. She explained that someone had called the van driver to assist with getting the resident out. LPN #1 further explained that when the residents returned from the fair, she had documented that Resident #1 had returned in the computer system but admitted that she had not actually observed him in the facility.</p> <p>On 10/28/24 at 3:40 PM, in a follow up interview with Front Office #1, she recalled giving a nurse the van key on 10/21/24 sometime before she got off work at 6:00 PM but was unable to recall why the key was needed, the exact she gave the key out, and the name of the nurse she gave the key to because there was a lot of activity in the lobby.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 4:15 PM, during a follow up interview with the Administrator, he reiterated that following the outing to the fair, the residents returned to the facility on [DATE] between 2:15 to 2:30 PM. Later that day, after leaving the facility for the day, he received a phone call from the DON, informing him that she received a phone call at or around 6:00 PM stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner to assess the resident. The next day, he received statements from the van driver and Front Office #1. The Administrator stated that he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for [AGE] years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM. He was also unaware that Front Office #1 had given the van key to a nurse around that same time. The Administrator was unable to explain the discrepancies in the statements made by the facility staff and the timeline of the event. The Administrator explained the facility held an emergency Quality Assurance (QA) meeting on 10/22/24 because a resident being left on the van for any amount of time could be an issue.</p> <p>On 10/29/24 at 9:27 AM, an interview with the Nurse Practitioner (NP) revealed on 10/21/24 at approximately 6:00 PM, he received a phone call from RN #1, stating that Resident #1 was left in the facility van for an undetermined amount of time. The NP explained that he did not witness Resident #1 being left in the facility's van. His note on 10/21/24 reflected to the best of his knowledge at the time of the incident what had been reported by the nursing staff. The NP stated he had provided an addendum to his note to clarify that he had no knowledge of how long the resident was left on the van. Following the incident as it was reported to him, he ordered basic blood work as the concern was that the resident had been left on the van for an undetermined amount of time.</p> <p>On 10/29/24 at 9:57 AM, an interview with the DON confirmed on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but that he had been found in the facility van. The NP was notified, and she had called the Administrator to let him know what the RN Supervisor had reported. She stated the facility completed in-services regarding completing documentation correctly since LPN #1 admitted that she had documented Resident #1 as being in the facility on 10/21/24 without seeing him. The facility also completed in-services on Abuse and Neglect.</p> <p>On 10/29/24 at 10:03 AM, in a follow up interview with RN #1, she stated that when it was reported to her that Resident #1 was missing, all staff started searching resident rooms, the shower room, and the outside courtyard. She did not issue a missing resident alert because he was found in the facility van. She confirmed that she went outside to the van and both the back and front door was open. She confirmed she observed the van driver return to the facility in his truck, and he was wearing a white t-shirt and shorts.</p> <p>In a follow up interview with LPN #1 on 10/29/24 at 5:15 PM, she stated she found Resident #1 in the facility van, secured in a seatbelt, and the van door was locked. She explained she went and got the keys from Front Office #1, and another staff member called the van driver, who quickly arrived back to the facility.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #1 on 6/24/23 with diagnosis including Unspecified Intellectual Disabilities and Dementia.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.</p> <p>A record review of the Quality Assessment and Assurance Committee Minutes October 22, 2024 revealed, . Emergency QA meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour .</p> <p>Record review of the Progress Note from the NP, dated 10/21/24, revealed, .Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair .At approximately 19:30 (7:30 PM) I came and evaluated the patient .Document e-signed .on [DATE] .</p> <p>Record review of the Addendum from the NP Progress Note revealed, Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours .Document e-signed on [DATE] .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to report a violation of neglect within 24 hours when the facility was notified that a resident had been left in a facility van for an undetermined amount of time for one (1) of three (3) residents. Resident #1</p> <p>Findings include:</p> <p>A review of the facility's policy, Abuse Investigation and Reporting Prevention Program, modified 8/2/22, revealed, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies .Reporting .2. An alleged violation of abuse, neglect .will be reported immediately, but not later than .b. Twenty-four (24) hours if alleged violation does not involve abuse AND has not resulted in serious bodily injury .</p> <p>During an interview with the Administrator on 10/28/24 at 4:15 PM, he stated that following the outing to the fair, the residents returned to the facility on [DATE] between 2:15 PM to 2:30 PM on the facility's transportation van. He confirmed that later that day after leaving the facility, he received a phone call from the Director of Nursing (DON) informing him that she had received a phone call at or around 6:00 PM from the facility staff stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner (NP) to assess the resident. The next day, he received statements from the van driver and Front Office #1 and he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for [AGE] years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM. However, he felt that since the facility always had eyes on the resident and his investigation was completed, he did not need to report the event to the State Agency (SA).</p> <p>During an interview on 10/29/24 at 9:57 AM, the DON, confirmed that on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but had been found in the facility van. She notified the Administrator, but did not report or investigate the event because the Administrator stated he would do the investigation.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #1 on 6/24/23 with diagnoses including Unspecified Intellectual Disabilities and Dementia.</p> <p>A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Quality Assessment and Assurance Committee Minutes October 22, 2024 revealed, . Emergency QA (Quality Assessment) meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour .</p> <p>Record review of the Progress Note from the NP, dated 10/21/24, revealed, .Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair .At approximately 19:30 (7:30 PM) I came and evaluated the patient .Document e-signed .on [DATE] .</p> <p>Record review of the Addendum from the NP Progress Note revealed, Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours .Document e-signed on [DATE] .</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41306</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to conduct a thorough investigation related to a resident who was left on the facility's transportation van upon return from an outing for one (1) of 3 (three) sampled residents. Resident #1</p> <p>Findings include:</p> <p>A review of the facility's policy, Abuse Investigation and Reporting, modified 8/2/22, revealed, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be .thoroughly investigated by facility management .Policy Interpretation and Implementation Role of the Administrator: 1. If an incident or suspected incident of resident .neglect .is reported, the Administrator or designee will lead the investigation .Investigative Process: 1. The individual conducting the investigation will, as a minimum .c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident .g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .j. Review all events leading up to the alleged incident .</p> <p>The Administrator stated during an interview on 10/28/24 at 11:20 AM, that on 10/21/24, following a trip to a local fair, five (5) residents were in the facility's transportation van. At approximately 2:45 PM the van returned to the facility and all the residents were unloaded except Resident #1. The van driver, who is also responsible for central supply, was requested to retrieve supplies for another resident. The front desk staff reported she always had eyes on the resident, while the resident was in the van alone, which was approximately 20 minutes. The Administrator confirmed that the Director of Nursing (DON) called him on 10/21/24 and advised him that Resident #1 was found inside the facility van at approximately 5:00 PM. The Administrator also stated that although the facility had video surveillance, the surveillance system was not operational on 10/21/24.</p> <p>The Administrator reiterated on 10/28/24 at 4:15 PM, during a follow up interview that following the outing to the fair, the residents returned to the facility on [DATE] between 2:15 to 2:30 PM. He confirmed that later that day, after leaving the facility, he received a phone call from the DON, informing him that she received a phone call at or around 6:00 PM stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner to assess the resident. The next day, he received statements from the van driver and Front Office #1 and he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for [AGE] years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM or any other facility staff that may have witnessed the incident. He also did not interview staff members on all shifts who had contact with the resident during the period of the alleged incident. The Administrator was unable to explain the discrepancies in the statements made by the facility staff and the timeline of the event. He stated that since the facility staff always had eyes on the resident, the investigations was completed, unsubstantiated, and required no further investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON confirmed during an interview on 10/29/24 at 9:57 AM, that on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but had been found in the facility's van. She notified the Administrator, but did not report or investigate the event because the Administrator stated he would do the investigation.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #1 on 6/24/23 with diagnoses including Unspecified Intellectual Disabilities and Dementia.</p> <p>A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.</p> <p>A record review of the Quality Assessment and Assurance Committee Minutes October 22, 2024 revealed, . Emergency QA (Quality Assessment) meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour .</p> <p>Record review of the Progress Note from the NP, dated 10/21/24, revealed, .Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair .At approximately 19:30 (7:30 PM) I came and evaluated the patient .Document e-signed .on [DATE] .</p> <p>Record review of the Addendum from the NP Progress Note revealed, Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours .Document e-signed on [DATE] .</p>		