

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Mitchell-Hollingsworth Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 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 as needed, 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 on it hurts. CNA noticed a red area above her lin Resident Assistant who also responded to the residents walked with</p>		