STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(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 a Complaint Investigation (CI), MS #22783, at the facility on 10/5/23. The SA investigated CI MS #22783 related to call lights, rehabilitation services, and notification of the resident's change in condition. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600 and F656. The facility held a licence for 120 beds with a census of 77.	F 000		
F 600 SS=G	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 interviews, record review, and facility policy review, the facility failed to identify and provide treatment to an open scalp wound for one (1) of four (4) sampled residents. Resident #1	F 600	1. Resident #1 was sent to the emergency room on 9/18/2023 and discharged from the facility on 9/25/2023. 2. All Residents have the potential to be	11/11/23

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

Electronically Signed | 10/17/2023

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F 600	Continued From page 1 Findings Include: Review of the facility's policy, "Abuse Prevention Program", undated, revealed, " ...Our residents have the right to be free from ...neglect ..." Review of the facility's policy, "Skin Assessment" revised 11/1/2022, revealed " ...It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment...Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/ re-admission and weekly thereafter..." In a phone interview on 10/5/23 at 10:15 AM, with the Resident Representative (RR) and his wife, they stated they visited Resident #1 at the facility on 9/18/23 and the resident was wearing a bonnet. The wife stated that when she removed the bonnet, there was a bandage on her head that was discolored a brown color, and had no date written on the bandage to indicate when the bandage was applied. She said the area had drainage and was crusted around the edges, so she notified the nurse. The Nurse Practitioner (NP) assessed the resident and ordered the resident to be transferred to the hospital. The family revealed that when the resident arrived at the hospital, the hospital staff noted the bandages were unchanged. The family said the facility neglected to provide treatments to her scalp and failed to provide care to prevent a wound infection. Record review of the "Progress Note", dated	F 600	affected by the same deficient practice. 3. All nursing staff will be inserviced on the proper way to complete a body audit, abuse and neglect, and following the careplan by the director of nurse and staff development nurse. This inservice will be completed by 10/23/2023. All nurses will be observed by the staff development nurse performing a body audit by 10/23/23. the director of nursing, resident care coordinator and registered nurse supervisor completed a baseline body audit on all resident, completed on 10/17/23 4. The director of nursing will verify that residents with known skin issues have accurate body audits completed. Director of Nursing will visualize current wound and compare to most recent body audits weekly x 12 weeks beginning 10/16/2023. The Resident Care Coordinator or Director of Nursing will complete 10 body audits weekly x 12 weeks to verify that body audit is completed accurately, beginning 10/16/2023. All audits will be reviewed by the Quality Assurance and Assessment Committee x 3 months beginning 11/10/2023 to ensure sustained compliance.	

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F 600	Continued From page 2	F 600		

9/18/23, created by the facility's NP, revealed the "Chief Complaint/Nature of Presenting Problem" was "Wound infection of Scalp". The "History of Present Illness" was "Patient seen today per facility request for evaluation of wound infection for scalp ...Patient's family member is at bedside and reports concern for recurrent wound infection to her scalp. Patient currently has recurrent squamous cell carcinoma (a type of skin cancer) of her scalp and is currently receiving chemotherapy ...Patient previously treated ...in May. Scalp does have increased drainage and crusting with no foul odor noted ...Family request patient be sent to (Proper Name of Local Hospital) for further evaluation and treatment."

Record review of a "Discontinue Order", dated 6/12/23, for Resident #1, revealed a Physician's Order for "...Cleanse scalp with wound cleanser pat dry Apply Mupirocin Ointment every day shift" was discontinued on 6/12/23 and the reason for discontinue was "Wound healed per (Proper Name of Physician)." This was the last Physician's Order related to treatments for Resident #1's scalp in the medical record.

Record review of the of the "Discharge Summary Note", dated 9/25/23, from a local acute hospital revealed Resident #1 was admitted through the Emergency Department on 9/18/23 and was discharged from the hospital on 9/25/23, which was seven (7) days later. The "Hospital Course" of the summary note revealed, " ...At presentation, she had unchanged dressings on her wounds. Family was concerned of adult neglect at the facility ...Squamous cell carcinoma of scalp ...Known to dermatology ...and oncology ..."

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Record review of the " ...Skin Only Evaluation", dated 8/6/23, revealed Licensed Practical Nurse (LPN) #2 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:45 PM, with LPN #2, she confirmed she completed a skin evaluation, or body audit, for Resident #1 on 8/6/23. LPN #2 explained that she failed to remove the resident's bonnet to assess her scalp during the skin evaluation. She stated she was not aware the resident had a bandage on her scalp and that she did not apply the bandage.

Record review of the " ...Skin Only Evaluation", dated 8/13/23, revealed Licensed Practical Nurse (LPN) #3 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 1:00 PM, with LPN #3, she confirmed she completed a skin evaluation/body audit for Resident #1 on 8/13/23. LPN #3 also confirmed she failed to remove the residents bonnet to assess her scalp. She explained she did not know there was a bandage on her scalp because she did not apply any bandages to the resident's head.

Review of the medical record revealed there were no skin evaluations for 8/20/23 or 8/27/23.

Record review of the " ...Skin Only Evaluation", dated 9/6/23, revealed Licensed Practical Nurse (LPN) #1 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:30 PM, with LPN #1, she confirmed she completed a body audit for Resident #1 on 9/6/23. LPN #1 also

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F 600	Continued From page 4	F 600		

confirmed she failed to remove the residents bonnet to assess her scalp area. She stated she did not apply any bandages to the resident's scalp and was not aware she had a bandage on her head.

Record review of the " ...Skin Only Evaluation", dated 9/10/23, revealed Registered Nurse (RN) #1 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:15 PM, RN #1 confirmed she failed to do a complete head-to-toe skin assessment on 9/10/23 for Resident #1. RN #1 explained she assessed the resident's skin, but she did not remove the bonnet to assess her head. RN #1 said she was not aware that Resident #1 had a bandage to her scalp, and she did not apply a bandage to that area.

During an interview on 10/5/23 at 1:12 PM, with Certified Nursing Aide (CNA) #1, she stated that she provides care to the Resident #1. She explained that she removed the bonnet and saw a bandage on the resident's head and only cleaned around he bandage when she gave the resident a shower.

During an interview on 10/5/23 at 1:20 PM, with CNA #2, she explained she provided care for Resident #1 prior to her hospitalization. CNA #2 stated Resident #1 had a bandage on her head, and she washed around the bandage. She stated that she thought the nurses knew about the drainage on the wound and was taking care of it.

During an interview on 10/5/23 at 1:30 PM, with the facility's NP, she confirmed she assessed

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Resident #1 because the family had concerns with her scalp. The NP said the resident had been wearing a bonnet, and upon assessment she noted an area on the scalp that had increased drainage, that was dry and crusted around the wound edges. The NP said she agreed with the family and sent the resident to the Emergency Department (ED) for evaluation because the resident had signs of infection to the scalp. The NP said she did not culture the wound because the resident is immunocompromised, due to chemotherapy. The NP explained that residents who receive chemotherapy should be assessed frequently and closely monitored for infections. The NP said that the nurses should have completed head-to-toe skin assessments on the resident for early detection and to prevent infection.

During an interview on 10/5/23 at 1:45 PM, with the Director of Nursing (DON), she confirmed the staff failed to do a head-to-toe skin assessment on Resident #1 and she did not realize this was not being done. The DON said she expected the staff to assess the resident head-to-toe when completing body audits. The DON revealed she did not know the residents wound had re-opened until the family came to visit and had concerns. The DON said she started in-services with the staff on appropriate body audits and the importance of reporting changes on the resident's body.

During an interview on 10/5/23 at 2:00 PM, with the Administrator, stated he expected staff to do a complete head-to-toe skin assessment to prevent further damage to a compromised resident.

Record review of the "Admission Record"

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F 600	Continued From page 6 revealed the facility admitted Resident #1 on 1/04/23 with diagnoses including Diabetes Mellitus and Carcinoma of the skin of scalp. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/18/23 revealed Resident #1 required a staff interview to assess cognition and her cognition was moderately impaired. Further review revealed she was totally dependent upon staff for Activities of Daily Living (ADL's).	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		11/11/23

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F 656	Continued From page 7 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to implement comprehensive care plan interventions related to skin assessments for one (1) of four (4) sampled residents. Resident #1 Findings Include: Review of the facility's policy, "Comprehensive Care Plans", revised 8/24/22, revealed, " ...It is the policy of this facility to ...implement a comprehensive person-centered care plan for each resident ...to meet a resident's medical, nursing, and mental and psychosocial needs ...Policy Explanation and Compliance Guidelines ...8. Qualified staff responsible for carrying out interventions specified in the care plan will be	F 656	1. Resident #1 was sent to the emergency room on 9/18/2023 and discharged from the facility on 9/25/2023. 2. All Residents have the potential to be affected by the same deficient practice. 3. All nursing staff will be inserviced on the proper way to complete a body audit, abuse and neglect, and following the careplan by the director of nurse and staff development nurse. This inservice will be completed by 10/23/2023. All nurses will be observed by the staff development nurse performing a body audit by 10/23/23. the director of nursing, resident care coordinator and registered nurse	

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F 656	Continued From page 8 notified of their roles and responsibilities for carrying out the interventions ..." Record review of the Comprehensive Care Plan revealed a "Focus" of "Resident has a dx (diagnosis) of carcinoma ...of skin of scalp ...", with a revision date of 7/11/2023. A review of the "Interventions" revealed, "Assess for s/s (signs and symptoms) of infection. Report to NP (Nurse Practitioner)." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 1/04/23 with diagnoses including Diabetes Mellitus and Carcinoma of the skin of scalp. Record review of the " ...Skin Only Evaluation", dated 8/6/23, revealed Licensed Practical Nurse (LPN) #2 documented that Resident #1 did not have current skin issues. On 10/5/23 at 12:45 PM, in an interview with LPN #2, she confirmed she did not remove the resident's bonnet to assess her scalp during the skin evaluation she conducted on 8/6/23. Record review of the " ...Skin Only Evaluation", dated 8/13/23, revealed Licensed Practical Nurse (LPN) #3 documented that Resident #1 did not have current skin issues. On 10/5/23 at 1:00 PM, during a phone interview with LPN #3, she confirmed she failed to remove the residents bonnet to assess her scalp when she completed the body audit on 8/13/23. Review of the medical record revealed there were no skin evaluations for 8/20/23 or 8/27/23.	F 656	supervisor completed a baseline body audit on all resident, completed on 10/17/23. A careplan will be completed for all residens with wounds by the Minimum Data Set Nurses to ensure that all interventions are implemented and followed. The careplan audit will be completed by 10/23/23 4. The director of nursining will verify resident with known skin issues have accurate body audits completed. Director of Nursing will visualize current wound and compare to most recent body audits weekly x 12 weeks beginning 10/16/2023. The Resident Care Coordinator or Director of Nursing will complete 10 body audits weekly x 12 weeks to verify that body audit is completed accurately, beginning 10/16/2023. Careplans for residents with wounds will be monitored weekly x 12 weeks, after skin audits are completed, beginning 10/19/23 by the Director of Nursing, Resident Care Coordinator, and Minimuum Data Set Nurses to ensure careplan interventions are implemented. All audits will be reviewed by the Quality Assurance and Assessment Committee x 3 months beginning 11/10/2023 to ensure sustained compliance.	

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F 656	Continued From page 9	F 656		

Record review of the " ...Skin Only Evaluation", dated 9/6/23, revealed Licensed Practical Nurse (LPN) #1 documented that Resident #1 did not have current skin issues.

On 10/5/23 at 12:30 PM, in an phone interview with LPN #1, she confirmed she failed to remove the residents bonnet to assess her scalp area on 9/6/23.

Record review of the " ...Skin Only Evaluation", dated 9/10/23, revealed Registered Nurse (RN) #1 documented that Resident #1 did not have current skin issues.

On 10/5/23 at 12:15 PM, in an interview with RN #1, she confirmed she failed to do a complete head-to-toe skin assessment on 9/10/23 for Resident #1.

In an interview on 10/5/23 at 1:45 PM, with the Director of Nursing (DON), she confirmed the facility staff failed to follow the care plan by not assessing the resident's scalp for signs and symptoms of infection.

In an interview at 2:10 PM on 10/5/23, with RN #2, she confirmed the facility failed to follow the care plan by not assessing the resident for signs and symptoms of infection. RN # 2 said she expected the staff to follow the care plan when taking care of the residents.